PART I

Item 1. Business.

In this report, "WellChoice," "Company," "registrant," "we," "us," and "our" refer to WellChoice, Inc., a Delaware corporation, and as the context requires, its subsidiaries.

This report contains forward-looking statements (within the meaning of the Private Securities Litigation Reform Act of 1995) that include information about possible or assumed future sales, results of operations, developments, regulatory approvals or other circumstances. Statements that use the terms "believe," "expect," "plan," "intend," "estimate," "anticipate," "project," "may," "will," "shall," "should" and similar expressions, whether in the positive or negative, are intended to identify forward-looking statements. All forward-looking statements in this report are based on management's estimates, assumptions and projections and are subject to significant risks and uncertainties, many of which are beyond our control. Important risk factors could cause actual future results and other future events to differ materially from those estimated by management.

For a more detailed discussion of these and other important factors that may materially affect WellChoice, please see our existing and future filings with the Commission, including the risk factors set forth in "Item 1. Business – Additional Factors That May Affect Future Results of Operations" and those contained in "Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations" and elsewhere in this report. Except as required by applicable law, including the securities laws of the United States, we do not intend to update or revise any forward-looking statements.

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Our website address is www.wellchoice.com. We make available free of charge through our website our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to those reports as soon as reasonably practicable after such material is electronically filed with or furnished to the Commission.

Company Overview

We are the largest health insurance company in the State of New York based on PPO and HMO membership. At December 31, 2004, we served approximately 5.0 million members through our service areas. Our service areas include 10 downstate New York counties, which we refer to as the "New York City metropolitan area," and where we hold a leading market position covering over 22% of the population, 18 counties in upstate New York and 16 New Jersey counties.

We have the exclusive right to use the Blue Cross and Blue Shield names and marks for all of our health benefits products in ten counties in the New York City metropolitan area and in six counties in upstate New York and the non-exclusive right to use these names and marks in one upstate New York county. In addition, we have an exclusive right to use only the Blue Cross names and marks in seven counties in our upstate New York service area and a nonexclusive right to use only the Blue Cross names and marks in an additional four upstate New York counties. Our membership in the Blue Cross Blue Shield Association also enables us to provide our PPO, EPO and indemnity members access to the national network of providers through the BlueCard program. This program allows these members access to in-network benefits through the networks of Blue Cross Blue Shield plans throughout the United States and over 200 foreign countries and territories. Substantially all of our revenues, and nearly all of our membership, is derived from the sale of our Blue Cross Blue Shield products and services.

Industry Overview

The managed health care industry has experienced significant change during the past few decades. The increasing focus on health care costs by employers, the government and consumers has led to the growth of

alternatives to traditional indemnity health insurance. HMO, PPO, EPO and POS plans are among the current forms of managed care products that have developed in response to these market pressures. Under these arrangements, the cost of health care is contained, in part, by negotiating contracts with hospitals, physicians and other providers to deliver care at favorable rates and adopting programs to ensure that appropriate and cost-effective care is provided.

In addition, economic factors and greater consumer awareness have resulted in the increasing popularity of products that offer larger, more extensive networks, more member choice related to coverage and the ability to self-refer within those networks. There is also a growing preference for greater flexibility to assume larger deductibles and co-payments in exchange for lower premiums. There is growing interest in consumer-directed health plans that utilize health reimbursement accounts and health savings accounts, which are designed to enable members to exercise greater control and assume increased cost-sharing responsibility for their health benefits. At the same time, organizations and individuals are placing an increased focus on the quality of health care and the level of sophistication and customer service in delivering service. Employer groups and providers are also demanding prompt and accurate payment of claims, including automated claims payment options. There is also a growing preference among national accounts and other large groups to self-fund their health care costs rather than purchase an insured product.

The Blue Cross Blue Shield Association and its member plans also have undergone significant change. Historically, most states had at least one Blue Cross (hospital coverage) and a separate Blue Shield (physician coverage) company. Prior to the mid-1980s, there were more than 125 separate Blue Cross and/or Blue Shield companies, which we sometimes refer to as "Blue" plans. Many of these organizations have merged, reducing the number of Blue plans to 40 as of December 2004. We expect this trend to continue, with plans merging or affiliating to address capital needs and other competitive pressures. At the same time, the number of people enrolled in Blue Cross Blue Shield plans has been steadily increasing, from approximately 65.6 million in 1995 to more than 91 million at December 31, 2004 nationwide.

The Blue Cross Blue Shield plans work together in a number of ways that create significant market advantages, especially when competing for large, multi-state employer groups. For example, all Blue Cross Blue Shield plans participate in the BlueCard program, which effectively creates a national "Blue" network. Each plan is able to take advantage of other Blue Cross Blue Shield plans' broad provider networks and negotiated provider reimbursement rates. Utilizing the BlueCard program, an indemnity, PPO or EPO member of one plan who lives or travels outside of the service area, in which the policy under which he or she is covered may obtain health care services from a provider that has contracted with the Blue Cross Blue Shield plan in the locale in which such member is then situated. This makes it possible for individual Blue Cross Blue Shield plans to compete for national accounts business with other non-"Blue" plans with nationwide networks.

Our Strategy

Our goal is to be the leading health insurer in the New York marketplace and surrounding areas. Over the past decade, we have implemented strategic changes to achieve this goal, including shifting our membership base from purchasers of mainly traditional indemnity products to more innovative managed care products. We plan to continue to maintain and improve our market position and financial performance by executing the following strategy:

- *Capitalize on Growth Opportunities.*
    - Offer a broad spectrum of managed care products in our local markets. We intend to continue to grow our business in our local markets, particularly in the small group and middle market customer segment, by maintaining, developing and offering the broad continuum of managed care products that the New York market demands. Generally, the breadth and flexibility of our benefit plan options are designed to appeal to a variety of employer groups and individuals with differing product and service preferences. We believe that customer needs will continue to change, requiring

us to increase the variety of products we offer. Product variations will include freedom in selecting providers, cost sharing, scope of coverage and the degree of medical management.

- *Grow our national accounts business.* We view national accounts as an attractive growth opportunity, as this group represents approximately 35% of employed persons in the United States. We believe our position in the New York City metropolitan area, where a significant number of national businesses have headquarters, provides us with a competitive advantage in our efforts to grow this business. In addition, we intend to continue to grow our national accounts business through the promotion of the BlueCard program.
- *Expand geographically.* We also intend to pursue expansion opportunities, especially those in or adjacent to our current service areas. We believe that we have developed an expertise in systems migration, network development, marketing, underwriting and cost control that is transferable to attractive markets within and outside New York and which positions us to take advantage of opportunities that may arise as the consolidation of the health insurance industry continues.

- *Leverage the Strength of the Blue Cross and Blue Shield Brands.* We believe that our license to use the Blue Cross and Blue Shield names and marks gives us a significant competitive advantage in New York, and we intend to continue to promote the value of these brands to attract additional customers and members.
- *Continue to Promote the Use of Medical Information to Offer Innovative Products and Services to Members and Providers.* We intend to be a leader in the use of medical information to facilitate and enhance communications and delivery of service among employers, employees and health care providers. We believe that our members and the market will increasingly desire and demand ready access to a repository of comprehensive, accurate and secure medical and health-related information that can be transmitted by the member to physicians and medical institutions.
- *Reduce Costs through Operational Excellence.* We seek to achieve operational excellence by improving delivery of service, customer satisfaction and financial results through high levels of performance accompanied by cost containment.

Our New York Regional Markets

New York is the third most populous state in the United States, with a total population of approximately 19.2 million, according to the most recent U.S. census estimates. We believe we can increase our market share through focused marketing efforts on a cost-effective basis, given the high population density in selected markets such as the New York City metropolitan area. The New York marketplace is comprised of a diverse customer base requiring a broad range of product offerings, and we believe our extensive experience and history of operating in this unique marketplace combined with our leading market share and brand recognition provide us with a distinct competitive advantage.

We operate in 28 counties in eastern New York, including the ten counties in the New York City metropolitan area, and 16 counties in New Jersey.

In our New York service area, we provide our products and services utilizing one or both of the Blue Cross Blue Shield brands through our indirect, wholly owned subsidiaries, Empire HealthChoice Assurance, or Empire, a New York licensed accident and health insurer, and Empire HealthChoice HMO, a New York licensed HMO. We utilize these brands to market to local groups and individuals in our New York service area as well as to national account customers. As of December 31, 2004, approximately 24.8% of our members were covered under national accounts. The national accounts are generally self-funded accounts to which we provide our products on an administrative services only, or ASO, basis with their employees having access to a nationwide network of providers through the BlueCard program.

Our New Jersey operations are operated under the WellChoice brand comprised of WellChoice Insurance of New Jersey and Empire HealthChoice HMO d/b/a WellChoice HMO of New Jersey, which engages in managed

care business in New Jersey. Our New Jersey operations were launched in 1998 and offer a comprehensive network of providers across Northern, Central New Jersey and the Southern New Jersey counties of Burlington, Camden and Ocean.

The following table demonstrates our service areas by region (including in New Jersey), population (based on 2003 U.S. Census Bureau estimates), membership by residence (as of December 31, 2004) and branding:

Region	Counties	Population (in thousands)	Membership (1) (in thousands)	Branding
New York City Metropolitan area	New York, Bronx, Richmond, Queens, Kings, Nassau, Suffolk, Westchester, Rockland, Putnam	12,226	2,708	Exclusive licenses to use Blue Cross and Blue Shield names and marks
Upstate New York	Dutchess, Orange, Sullivan, Ulster, Columbia, Greene	1,022	253	Exclusive licenses to use the Blue Cross and Blue Shield names and marks
	Delaware	47	6	Non-exclusive licenses to use the Blue Cross and Blue Shield names and marks
	Albany, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	967	173	Exclusive license to use only the Blue Cross names and marks
	Clinton, Essex, Fulton, Montgomery	225	35	Non-exclusive license to use only the Blue Cross names and marks
New Jersey	Bergen, Burlington, Camden, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, Warren	7,792	245(2)	WellChoice

(1) The membership in the table excludes the approximately 1,535,000 members that reside outside of our New York and New Jersey service areas.

(2) Of this membership, approximately 231,000 members are covered by group policies issued by our New York operations and approximately 14,000 are members of our WellChoice NJ operations.

Our Business Segments

We have two business segments: commercial managed care and other insurance products and services. Our commercial managed care segment accounted for 88.4% of our membership as of December 31, 2004. Our commercial managed care segment includes group PPO, HMO (including Medicare+Choice), EPO, and other products (point of service, or POS, and dental-only coverage) as well as our PPO business under our accounts with New York City and New York State. Our other insurance products and services segment consists of our indemnity and individual products. Our indemnity products include traditional indemnity products and government contracts with CMS to act as a fiscal intermediary and carrier. Our individual products include

Medicare supplemental, state sponsored plans, government mandated individual plans and individual hospital-only and hospital and medical products. We allocate administrative expenses, investment income and other income, but not assets, to our segments. Except when otherwise specifically stated or where the context requires, all references in this document to our membership include both our insured and ASO membership. Our New York City and New York State PPO account members are covered under insured plans. Groups enrolled under minimum premium arrangements are reported as insured members.

Revenues from external customers, investment income and realized gains, other revenue and income from continuing operations before income tax expense attributable to each of our reportable segments are set forth in Note 17 to the Consolidated Financial Statements, which are included elsewhere in this report. Assets are not allocated to the segments. We do not have inter-segment sales or expenses.

Health Care Benefits, Products and Services

We offer a wide range of health insurance products. Our offerings include managed care products consisting of HMO, POS, PPO and EPO plans and traditional indemnity products. Our principal health products are offered both on an insured and, except with respect to our HMO products, self-funded, or ASO, basis and, in some instances, a combination of insured and self-funded. For the years ended December 31, 2004, 2003 and 2002, our PPO and HMO products accounted for 47.0%, 48.1% and 46.8%, respectively, and 25.9%, 23.1% and 22.6%, respectively, of our total revenues. No other product or services accounted for 10% or more of our total revenues.

The following table illustrates our health benefits membership by product as of December 31, 2004:

	Membership (in thousands)	Percentage
Commercial managed care:		
Group PPO, HMO, EPO and other(1)(2)	2,558	51.6%
New York City and New York State PPO	1,823	36.8
Total commercial managed care	4,381	88.4
Other insurance products and services:		
Indemnity	364	7.4
Individual	210	4.2
Total other insurance products and services	574	11.6
Overall total	4,955	100.0%

(1) Our HMO product includes Medicare+Choice. As of December 31, 2004, we had approximately 56,000 members enrolled in Medicare+Choice.

(2) "Other" principally consists of our members enrolled in dental only coverage and includes POS members.

Commercial Managed Care Products

Managed care generally refers to a method of integrating the financing and delivery of health care within a system that manages the cost, accessibility and quality of care. Managed care products can be further differentiated by the types of provider networks offered, the ability to use providers outside such networks and the scope of the medical management and quality assurance programs. Our members receive medical care from our networks of providers in exchange for premiums paid by the individuals or their employers and, in some instances, a cost-sharing payment by the member. We reimburse network providers according to pre-established fee arrangements and other contractual agreements.

We currently offer the following managed care plans: an HMO product, a PPO product, an EPO product and a POS product.

HMO. Our HMO plan provides members and their dependent family members with all necessary health care for a fixed monthly premium in addition to applicable member co-payments. Health care services can include

emergency care, inpatient hospital and physician care, outpatient medical services and supplemental services, such as behavioral health and prescription drugs. Under our standard HMO product, members must select a primary care physician within the network to provide and assist in managing care, including referrals to specialists. We also offer a Direct Connection HMO product, which offers all the advantages of our standard HMO product, but allows our eligible members to seek care from in-network specialists without a referral. HMO members do not have access to services on a national account basis through the BlueCard program. We also provide services to Medicare beneficiaries through our Medicare+Choice product, which covers all Medicare covered services, Medicare deductibles and coinsurance and certain additional services. HMO members receive all covered medical care through physicians selected from the applicable HMO provider network.

PPO. Similar to an HMO, a PPO managed care plan provides members and their dependent family members with health care coverage in exchange for a fixed monthly premium. Our PPO provides its members with access to a larger network of providers than our HMO. A PPO does not require a member to select a primary care physician or to obtain a referral to utilize in-network specialists. In contrast to an HMO product, a PPO also provides coverage for members who access providers outside of the network. Out-of-network benefits are usually subject to a deductible and coinsurance. Our PPO also offers national in-network coverage to its members through the BlueCard program. For our New York State and New York City accounts we provide a hospital-only network PPO benefit.

Effective January 1, 2005, as part of our PPO product offerings, we introduced a new consumer directed health care product to self-insured groups and large insured groups. The new product is a high-deductible managed care health plan that is designed to lower premiums for employers and to involve consumers more directly in their health care spending. Consumer directed health plans enable an employer and/or employee to contribute to each participating employee's health account to pay for certain medical and pharmaceutical expenses. Some or all of the dollars remaining at the end of the year can be rolled over for future health care needs.

EPO. Our EPO plan is similar to our PPO managed care plan but does not cover out-of-network care. Members may choose any provider from our PPO network in our New York service area and do not need to select a primary care physician. Outside of our service area in New York State, EPO members may use the BlueCard program to secure in-network benefits nationally. We currently offer an EPO product to New York State employers on both an insured and self-funded basis and to national accounts only on a self-funded basis. For national accounts needing coverage in jurisdictions where the EPO product is prohibited, we offer a variation of this product that requires a 50% coinsurance payment for out-of-network services.

POS. Our point of service, or POS, product focuses primarily on local small and middle market customers. The product, Direct POS, provides members with the ability to utilize services on an in-network basis utilizing our HMO network of providers or on an out-of-network basis. POS members do not have access to services on a national account basis through the BlueCard program. Our POS product has similar features to our Direct Connection HMO product that permits members to access in-network specialists without a referral, and also allows members to access out-of-network providers in return for deductibles and/or co-insurance. We believe the POS product complements our existing managed care product portfolio by offering employers an additional product within our family of managed care products to meet the needs of their employees.

In addition, we offer dental coverage on a PPO basis and other dental managed care products.

Other Insurance Products and Services

We provide indemnity health insurance, which generally reimburses the insured for a percentage of actual costs of health care services rendered by physicians, hospitals and other providers. Our indemnity products include hospital-only coverage as well as comprehensive hospital and medical coverage.

We also offer a number of individual products, including Child Health Plus, Medicare supplemental, direct pay hospital-only, Healthy New York (regardless of whether purchased by groups or by individuals) and the New York State-mandated direct pay HMO and HMO-based POS products. Child Health Plus provides a managed care product similar to our HMO products to children under the age of nineteen who are ineligible for Medicaid and not otherwise insured. Our Medicare supplemental insurance policies, also referred to as Medigap policies, are designed to supplement Medicare by paying hospital, medical and surgical expenses as well as, in some cases, prescription drug expenses for a portion of those costs not covered by Medicare. Direct pay hospital-only is a low-cost policy that covers in-patient and out-patient services on an indemnity basis. Healthy New York, direct pay HMO and HMO-based POS products are state-mandated HMO products.

We also serve as fiscal intermediary for the Medicare Part A program and a carrier for the Medicare Part B program, for which we receive reimbursement of certain costs and expenses at predetermined levels.

Administrative Services Only

In addition to our insured plans, we also offer selected products, including PPO, EPO and indemnity benefit designs, on a self-funded, or ASO, basis under which we provide claims processing and other administrative services to employers. Employers choosing to purchase our products on an ASO basis fund their own claims but their employees are able to access our provider network at our negotiated discounted rates. We administer the payment of claims to the providers but we do not bear any insurance risk in connection with claims costs because we are reimbursed in full by the employer. The administrative fee charged to self-funded groups is generally based on the size of the group and services provided. Our primary ASO customers are large national accounts and large local groups (over 1,000 employees).

BlueCard

For our members who purchase our PPO, EPO and indemnity products under a Blue Cross Blue Shield plan, we offer the BlueCard program. The BlueCard program offers these members in-network benefits through the networks of the other Blue Cross Blue Shield plans in other states and regions. In addition, the BlueCard program offers our PPO, EPO and indemnity members in-network coverage in over 200 countries and territories. We believe that the national and international coverage provided through this program allows us to compete effectively with large national insurers, without compromising our focus and concentration in our geographical region. We derive fees from other Blue Cross Blue Shield plans when their members receive medical care from providers in our service areas. In 2004, approximately 510,000 members of other Blue Cross Blue Shield plans utilized our provider networks through the BlueCard programs. We also pay other Blue Cross Blue Shield plans' fees when our members receive medical care from providers in those other plans' service areas.

Marketing and Distribution

Our marketing activities concentrate on promoting our strong brands, quality care, customer service efforts, the size and quality of our provider networks, our financial strength and the breadth of our product offerings. We distribute our products through several different channels, including our salaried and commission-based internal sales force, independent brokers and telemarketing staff. We also use our website to market our products.

Branding and Marketing. Our branding and marketing efforts include "brand advertising," which focuses on the Blue Cross and Blue Shield names and marks, "acquisition marketing," which focuses on attracting new customers, and "institutional advertising," which focuses on our overall corporate image. We believe that the strongest element of our brand identity is the "Blue Cross and Blue Shield." We seek to leverage what we believe to be the high name recognition and comfort level that many existing and potential customers associate with this brand. Also, the BlueCard program is an important component of our Blue Cross Blue Shield marketing strategy as it enables us to compete for large, multi-state employer groups. Acquisition marketing consists of business-to-business marketing efforts which are used to generate leads for brokers and our sales force as well as direct-to-

consumer marketing which is used to add new customers to our direct pay businesses. Institutional advertising is used to promote key corporate interests and overall company image. We believe these efforts support and further our competitive brand advantage. Our strategy will be to continue utilizing the Blue Cross and/or Blue Shield brands for all products and services in our service areas in New York and to continue to establish the WellChoice brand outside of New York.

Distribution. As of December 31, 2004, our sales force consisted of over 100 people. We also utilize the services of approximately 4,900 independent brokers in New York and approximately 2,100 in New Jersey. We rely on independent brokers to market our products to small and middle market groups. In addition, we engage 13 general agents to distribute our products in New Jersey, as well as ten general agents to distribute our products to middle market and large groups in New York. Several account representatives and managers are dedicated exclusively to maintaining our relationships with our national accounts and labor union customers. Our internal telemarketing division is primarily responsible for marketing our managed health care plans to small groups. Our sales staff is primarily responsible for marketing our managed health care plans to small and large groups, either directly or working with a broker. We believe that each of these marketing methods is optimally suited to address the specific health insurance needs of the customer base to which it is assigned.

We compete for qualified brokers and agents to distribute our products. Strong competition exists among health insurance companies and health benefits plans for brokers and agents with demonstrated ability to secure new business and maintain existing accounts. The basis of competition for the services of such brokers and agents are commission structure, support services, reputation and prior relationships, the ability to retain clients and the quality of products. We believe that our brokers gain significant benefits from our dedicated broker website, which enables them to obtain quotes for our small group products and perform administrative services for existing accounts. We believe that we have good relationships with our brokers and agents, and that our products, support services and commission structure are highly competitive in the marketplace.

Customers

The following chart shows our membership by customer group at December 31, 2004:

	Membership (in thousands)	Percentage
Large group	2,986	60.3%
Small group and middle market	472	9.5
Individuals	266	5.4
National accounts	1,231	24.8
Total	4,955	100.0%

We sell products to customers ranging in size from large national institutional accounts to individuals. We continually seek to obtain an optimal and balanced portfolio of business across all of our customer segments.

Large Groups. This customer base consists of large organizations with operations in our service areas that have more than 500 employees and includes New York State, New York City and local governmental employers and labor unions. Our large corporate accounts purchase our products on both an insured and ASO basis. We sell our products to New York State and New York City in their capacity as employers. As of December 31, 2004, our New York State and New York City accounts represented approximately 20.1% and 16.6%, respectively, of our total membership, and labor unions represented 11.3% of our total membership. We provide hospital-only coverage to both the New York State and New York City accounts. The New York State and New York City PPO business accounts for approximately 19% and 15% of total premium earned, respectively during 2004, and no other customer accounted for more than 10% of our revenues.

Small Group and Middle Market. This customer base consists of small (two to 50 employees) and mid-sized (51 to 500 employees) companies. Our small groups have tended to purchase HMO products, while our middle market groups are covered by a mix of our HMO, PPO and EPO products and by other products, including POS.

We intend to continue to grow our small group and middle market customer base. To that end, in 2003, we introduced a POS product for this market. The product, which utilizes our HMO network of providers, offers members the ability to utilize services on an in- or out-of-network basis. In-network specialists may be accessed without a referral while members may access out-of-network providers in return for deductibles and/or co-insurance.

Individuals. This customer base consists principally of members who utilize our government-related products, including Child Health Plus, Medicare supplemental, Medicare+Choice, Healthy New York and two New York State-mandated direct pay HMO and HMO based POS products.

National Accounts. National accounts consist of large multi-state employers for whom technology, flexibility, access to the BlueCard program and single-point accountability are important factors. National accounts often engage consultants to work with our in-house sales staff to tailor benefits to their needs. Substantially all of our national accounts purchase our products on an ASO basis. In order to provide ASO services and access to the BlueCard program to customers that are headquartered outside of our licensed areas, we are required under our Blue Cross and Blue Shield licenses to obtain the consent of the Blue Cross Blue Shield plan licensed in the service area in which the customer is headquartered, a process referred to as "ceding."

Underwriting and Pricing

Disciplined underwriting and appropriate pricing are core strengths of our business and we believe are an important competitive advantage. We continually review our underwriting and pricing guidelines on a product-by-product and customer group-by-group basis in order to maintain competitive rates in terms of both price and scope of benefits. As a result of our disciplined approach to underwriting and pricing, we have attained consistent profitability in our insured book of business.

Our claims database enables us to establish rates based on our own experience and provides us with important insights about the risks in our service areas. We tightly manage the overall rating process and have processes in place to ensure that underwriting decisions are made by properly qualified personnel. In addition, we have developed and implemented a process to detect fraudulent groups, employees and providers.

Our rating policies in New York differ by group size product offerings. Our middle market and large group accounts for EPO, PPO, POS and indemnity products are experience rated. This means that our premium rate for each of these accounts is calculated based upon demographic criteria such as age, gender, industry and region and experience criteria, referring to the actual cost of providing health care to that group during a period of coverage. For middle market groups, the rates are set prospectively, meaning that a fixed premium rate is determined at the beginning of the policy period. We are at risk for negative experience (actual claim costs and other expenses are more than those expected) and benefit from positive experience (claim costs and other expenses are less than expected). For large groups with PPO, EPO or traditional indemnity benefit designs, we employ prospective and retrospective ratings. Our New York City and New York State accounts are retrospectively rated. In retrospective rating, a premium rate is determined at the beginning of the policy period. Once the policy period has ended, the actual experience is reviewed. If the experience is positive, a refund is credited to the customer. If the experience is negative, then the deficit is recovered from future years' premiums. If the customer elects to terminate coverage, deficits cannot be recovered.

Our HMO products sold in New York State, as well as all other insured products purchased by small groups and individuals, are community rated. The premiums for community rated products are set according to our expected costs of providing medical benefits to the community pool as a whole, rather than to any customer or sub-group of customers within the community. We cannot factor in other criteria in rating our premiums for these products, other than Medicare eligibility. We use a variation of community rating in New Jersey for all small group products. All of our community rated products in New Jersey are determined based on a community pool according to the age, sex and county of residence of the members. Both the New York and New Jersey community rated products are set prospectively.

With respect to our Medicare+Choice plan, we have a contract with the Centers for Medicare and Medicaid Services, or CMS, to provide HMO Medicare+Choice coverage to Medicare beneficiaries who choose health care coverage through our HMO program in New York City and Nassau, Suffolk, Rockland and Westchester counties in New York State. Under this annual contract, CMS pays us a set rate based on membership that is adjusted for demographic factors and health status. At December 31, 2004, we had approximately 56,000 members enrolled in Medicare+Choice, or 1.3% of our commercial managed care membership. Medicare+Choice accounted for 11.1% of our commercial managed care premium revenue for the year ended December 31, 2004. In some counties in which we offer the Medicare+Choice program, we receive additional premiums from our members.

Quality Initiatives and Medical Management

Our approach to quality initiatives and medical management seeks to ensure that high quality care is provided to our members. For purposes of our quality programs, we segment our membership into four health categories (healthy, acute, chronic and complex) and allocate our resources to facilitate the delivery of quality health care appropriate for each segment. Our quality initiatives and medical management approach seeks to improve member health, to avoid health risks and to lower costs. We use sophisticated healthcare information technologies to identify those members who incur a disproportionate amount of health care costs for treatment and hospitalization. We use this information to work with physicians to develop appropriate programs intended to improve member health and thereby minimize future claims expenditures.

A small portion of our insured commercial managed care members who have both medical and hospital coverage constitutes a significant majority of our hospital and medical claims expenses. We are focusing on controlling these costs by using innovative technology, including sophisticated databases that can identify and monitor specific members who have the potential for high costs of benefits provided. Our programs are built upon nationally recognized guidelines. We use statistical modeling techniques as well as data generated through our claims system to help identify members in high-risk populations.

In addition, our SARA initiative, which is offered to our ASO accounts and some insured groups and provided to HMO members who are at least 50 years of age, serves as an early intervention program with a goal of identifying potential issues in physician-recommended treatments. The SARA program uses our claims system to generate and analyze medical, laboratory, pharmacy and hospital claims data with the goal of identifying patients at risk of potentially serious medical conditions and alerting physicians of identified risks, such as adverse drug reactions, skipped preventive screenings and overlooked tests. Depending on the identified risk, members may also be alerted on-line in the secure site in their SARA messaging center.

In addition, we have developed and provide a variety of services and programs for the acute, chronic and complex populations as well as on-line and off-line educational materials to help keep members healthy. The services and programs seek to enhance quality by eliminating inappropriate hospitalizations or services and eliminating possible complications of procedures performed in hospitals. These services and programs include pre-certification and concurrent review hospital discharge services for acute patients, as well as disease management programs for the chronic care population and nurse case managers for complex population members.

Effective October 2003, we consolidated and broadened our disease management programs by contracting with American HealthWays, Inc. to provide comprehensive disease management services to members with chronic conditions, including the following core conditions: asthma, diabetes, congestive heart failure, coronary artery disease and chronic obstructive pulmonary disease. All of the disease management programs for the core conditions outsourced to American HealthWays are included in our insured products while those and others are offered to self-funded groups. We also have arrangements with two other disease management companies to provide specialized support services for members with other chronic care conditions, such as Parkinson's disease, multiple sclerosis, lupus and kidney failure.

In 2004 we introduced "Hospital IQ," a web-based tool that provides members with easy access to hospital patient safety data. "Hospital IQ" permits members to identify and select hospitals for treatment based on a variety of criteria, including proven patient safety standards that are linked to improved outcomes and reduced costs. The program aims to improve patient safety in hospitals by giving consumers information to make more informed hospital choices. Hospital IQ utilizes objective, nationally accepted standards from organizations such as the Agency for Healthcare Research and Quality and The Leapfrog Group, as well as data from state health departments. The Leapfrog Group is sponsored by the Business Roundtable, a national association of Fortune 500 companies.

This tool was initially launched on a limited basis in 2002 through a pilot program, in conjunction with IBM, PepsiCo, Inc., Verizon Communications, Inc. and Xerox Corporation (four of our national accounts). Using what are known as Leapfrog Group standards the pilot program enabled our employees and employees of these accounts to access hospital volume data for five selected procedures/conditions for hospitals in New York.

We also encourage the prescription of formulary and generic drugs, instead of non-formulary equivalent drugs, through benefit design and member and physician interactions. In addition, through arrangements with our pharmacy benefit manager, AdvancePCS, we are able to obtain discounts and rebates on certain medications through bulk purchasing.

We have integrated medical policies, which we derive from CMS and commercial and industry standard sources, into our claims processing systems. This integration substantially enhances the quality and accuracy of our claims adjudication process.

Information Systems and Telecommunications Infrastructure

The development and enhancement of our information technology systems and integrated voice and data capabilities has been, and continues to be, a key component of our strategy of operational excellence. We have spent significant time and resources enhancing the capabilities of our customer service systems. We have consolidated multiple claims systems into one platform; in 2004, we completed the migration of our national accounts claims, which have been processed by National Accounts Service Company, LLC, or NASCO, an entity in which we held an equity interest until the end of 2004, into our other claims platform. In addition, we have implemented innovative voice and data technologies that link most of our office locations, allowing us to broadcast and communicate in real-time to our employees' desktops.

We believe that our success in enhancing and consolidating our information systems provides us with a distinct competitive advantage that will allow us to grow our business organically as well as through potential strategic acquisitions. We believe our experience in this area will allow the integration of other information technologies and processes into our own in a timely and efficient manner.

Collaborations

In addition to developing technological and managerial capabilities internally, we also collaborate with third parties to develop new systems, technologies and capabilities. These collaborations allow us to leverage the core strengths of third parties to create better quality of service for our customers as well as to increase efficiencies of our internal systems and processes. We are currently involved in a major collaboration with the goal of substantially enhancing our technological capabilities and cost efficiencies.

IBM. In June 2002, we entered into a ten-year master services agreement with IBM to enhance and modernize our systems applications and operate our data center and technical help desk. Our payments to IBM for software application services and for operating our data center and technical help desk are based upon actual utilization of services billed at the rates established in the agreement. Under the terms of the IBM agreement we cannot perform or engage a third party to perform any of the data center or technical help desk services, or more

than 20% of the in-scope core applications software services, outsourced to IBM without the written consent of IBM. We estimate that our payments to IBM for operating our data center and technical help desk and providing certain core applications software development will total approximately $447.2 million over the remaining term of the agreement.

Pursuant to the IBM agreement, we have undertaken to work jointly with IBM to enhance our systems applications. Some of the systems application software development is being performed overseas from IBM's offices in Bangalore, India. In the event this facility becomes unavailable during the life of the agreement, IBM has agreed to provide these services from a replacement facility. These applications include technological enhancements based on the ongoing requirements of our business and solutions developed based upon our specifications. We will own the software developed by IBM under the agreement.

Aware Dental. We have outsourced a significant portion of the management of our dental products to Aware Dental Services, LLC of Minnesota. Aware Dental Services, a joint venture between De Care International and Blue Cross and Blue Shield of Minnesota, provides dental development, management and administrative services in connection with dentist networks. Under this arrangement, Aware Dental is responsible for customer service, underwriting and pricing, provider contracting, claims processing and utilization management. We retain responsibility for membership and billing services, and we share joint responsibility with respect to the marketing and sales of our products, information technology, product development and design and regulatory filings.

Provider Arrangements

We have the largest HMO and PPO provider networks of any health insurer or HMO in our New York service area. Our relationships with health care providers, physicians, hospitals, other facilities and ancillary health care providers are guided by state and national standards established by regulatory authorities for network development, service availability and contract methodologies.

In contrast to some health benefits companies, it is generally our philosophy not to delegate full financial responsibility for health services provided to our members to our providers in the form of capitation-based reimbursement. As a result, the vast majority of our providers are reimbursed on a discounted fee-for-service basis. Under these contracts, we aim to provide market-based reimbursement consistent with industry and market standards. We seek to ensure that providers in our networks are paid in a timely manner. We seek to maintain broad provider networks to ensure member choice while implementing effective management programs designed to improve the quality of care received by our members. For some ancillary services, such as behavioral health and laboratory services, we have entered into capitation arrangements with entities that offer broad-based services through their own contracts with providers.

To build our provider networks, we compete with other health benefits plans for contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider member volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities when deciding whether to contract with a health benefits plan.

Hospitals. We contract with our hospitals to reimburse them for services provided to our members on both a per diem and case rate basis. We have recently seen a trend toward case rate reimbursement, which in contrast to per diem rates, provides for the payment of a fixed fee to cover all hospital services required to treat a particular condition or episode of illness. We have multi-year contracts with approximately 90% of the hospitals in our New York network, which have varying termination provisions ranging from termination only for cause to termination for convenience on notice ranging from 90 to 365 days.

Physicians. Fee-for-service is our predominant reimbursement methodology for physicians. Our physician rate schedules applicable to services provided by in-network physicians are based on a resource-based relative value system fee schedule and then adjusted for competitive pressures in the market. This structure is similar to physician reimbursement methodologies developed and used by the federal Medicare system and other major payers.

With respect to Blue Cross and Blue Shield branded products in our New York service areas and counties that are contiguous to these areas, services are provided to our members through our network providers with whom we contract directly. Members seeking medical treatment outside of these areas are provided through the networks of the local Blue Cross and/or Blue Shield plan operating in that area through the BlueCard program. With respect to our New Jersey operations, we contract directly with physicians in our New Jersey service area and provide members outside of New Jersey with coverage through a third party national provider network.

Provider Portals. We utilize technology to deliver useful and practical information and services to our providers. Through the use of our physician portal, which we introduced in 2001, our network practitioners are able to submit their claims via the Internet, receive claim payment determinations in real-time and confirm member eligibility. In 2003, we introduced a portal to our network hospitals and other facilities enabling them to perform a variety of functions, including claim management, member eligibility and benefit confirmations on-line. In 2004, we made on-line benefit information available to physicians and hospitals and implemented a pilot program that allows members and providers to conduct on-line consultations for non-emergency medical issues.

Subcontracting. We subcontract for behavioral healthcare and pharmacy services through contracts with third parties. Behavioral health benefits are provided through Magellan Behavioral Health, Inc. under a capitation-based contract that we recently renewed through December 31, 2007. Under the agreement, Magellan arranges services through its network of behavioral health care providers. Magellan's care managers focus on access to appropriate providers and settings for behavioral health care services. Our contract with Magellan is capitation-based. In addition, we have extended our agreement with AdvancePCS through December 31, 2008, pursuant to which AdvancePCS, which was acquired by CareMark in 2004, provides pharmacy benefit management services to our members. These services include member services, retail pharmacy network contracting and management, mail pharmacy services, claims processing, payment of claims to participating pharmacies and drug rebate negotiations with manufacturers. We retain primary responsibility for formulary management and compliance, utilization management and pharmacy clinical policies and programs.

In addition, we have contracts with a number of other ancillary service providers, including home health agency providers and intermediate and long-term care providers, to provide access to a wide range of services. These providers are normally paid on either a fee schedule, fixed-per-day or per case basis.

Competition

The health insurance industry is highly competitive, both nationally and in New York and New Jersey. Competition has intensified in recent years due to more aggressive marketing and pricing, a proliferation of new products and increased quality awareness and price sensitivity among customers.

Industry participants compete for customers based on the ability to provide value which we believe includes quality of service and flexibility of benefit designs, access to and quality of provider networks, brand recognition and reputation, price and financial stability.

We believe that our competitive strengths, including the size and quality of our provider network, the broad range of our product offerings and our Blue Cross Blue Shield license position us well to satisfy these competitive requirements.

Competitors in our markets include national health benefits companies and local and regional for-profit and not-for-profit health insurance and managed care plans. Our markets for managed care products are generally more competitive than our markets for other products, including indemnity products. Our largest competitors in the New York City metropolitan area include national and regional health insurers, such as UnitedHealthGroup and its subsidiaries (including Oxford Health Plans), Aetna, Health Insurance Plan of Greater New York and Group Health Incorporated. We compete in upstate New York with other "Blue" plans, including HealthNow New York Inc., as well as other non-"Blue" plans, such as Capital District Physicians Health Plan and MVP

Health Plan. Our major competitors for national accounts customers include UnitedHealthGroup, Cigna Corporation, as well as other "Blue" plans. In New Jersey, we compete with several national health benefits companies and Horizon Blue Cross Blue Shield.

Blue Cross Blue Shield License

We have the exclusive right to use the Blue Cross and Blue Shield names and marks for all of our health benefits products in all ten counties in the New York City metropolitan area and in six counties in upstate New York and a non-exclusive right to use those names and marks in one upstate New York county. In addition, we have an exclusive right to use only the Blue Cross names and marks in seven counties in our upstate New York service area and a non-exclusive right to use only the Blue Cross names and marks in an additional four counties in upstate New York. We refer to these 28 counties in New York as our Blue Cross Blue Shield licensed territory. Subject to the ceding rules discussed below, we do not have any rights to use the Blue Cross and/or Blue Shield names and marks in New Jersey or elsewhere to market our products and services. We believe that the Blue Cross and Blue Shield names and marks are valuable identifiers of our products and services in the marketplace. The license agreements, which have a perpetual term (but which are subject to termination under circumstances described below), contain reserve requirements, discussed below under "Government Regulation—Capital and Reserve Requirements," and other requirements and restrictions regarding our operations and our use of the Blue Cross and Blue Shield names and marks.

Upon the occurrence of any event causing termination of the license agreements, we would cease to have the right to use the Blue Cross and Blue Shield names and marks in the Blue Cross Blue Shield licensed territory. We also would no longer have access to other "Blue" plan provider networks through the BlueCard program. We would expect to lose a significant portion of our membership if we lose these licenses. Loss of these licenses could significantly harm our ability to compete in our markets and could require payment of significant monetary penalties to the Blue Cross Blue Shield Association. Furthermore, the Blue Cross Blue Shield Association would be free to issue a license to use the Blue Cross and Blue Shield names and marks in the counties in New York in which we had previously used the Blue Cross and/or Blue Shield name and mark to another entity, which would have a material adverse affect on our business, financial condition and results of operations.

Events that could result in termination of our license agreements include:

- failure to maintain our total adjusted capital at 200% of authorized control level risk based capital, as defined by the NAIC risk based capital (RBC) model act;
- failure to maintain liquidity of greater than one month of underwritten claims and administrative expenses, as defined by the Blue Cross Blue Shield Association, for two consecutive quarters;
- failure to satisfy state-mandated statutory net worth requirements;
- impending financial insolvency;
- a change of control not otherwise approved by the Blue Cross Blue Shield Association; and
- a violation of the Blue Cross Blue Shield Association ownership limitations on our capital stock, including any amendment to the voting trust and divestiture agreement between us and The New York Public Asset Fund which is not approved by the Association or the failure of the Fund to reduce its stockholdings to the ownership limits within the timeframes set forth in that agreement.

The Blue Cross Blue Shield Association license agreements and membership standards specifically permit a licensee to operate as a for-profit, publicly traded stock company, subject to governance and ownership requirements.

Pursuant to the rules and license standards of the Blue Cross Blue Shield Association, we guarantee our contractual and financial obligations to respective customers. In addition, pursuant to the rules and license

standards of the Blue Cross Blue Shield Association, we have agreed to indemnify the Blue Cross Blue Shield Association against any claims asserted against it resulting from our contractual and financial obligations.

Each license requires an annual fee to be paid to the Blue Cross Blue Shield Association. The fee is determined based on premiums earned from products using the Blue Cross and Blue Shield names and marks and from a per-contract charge for self-funded membership. During 2004, 2003 and 2002, we paid fees to the Blue Cross Blue Shield Association in the amount of $5.1 million, $2.9 million, and $3.2 million, respectively. The Blue Cross Blue Shield Association is a national trade association of Blue Cross Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the Blue Cross Blue Shield names and marks, as well as to provide certain coordination among the member plans. Each Blue Cross Blue Shield licensee is an independent legal organization and is not responsible for obligations of other Blue Cross Blue Shield Association member organizations. Subject to the "ceding" rules discussed below, we have no right to market products and services using the Blue Cross Blue Shield names and marks outside our Blue Cross Blue Shield licensed territory.

Ceding. The rules and license standards of the Blue Cross Blue Shield Association set forth procedures with respect to the provision of insurance or administrative services to national accounts with employees located in numerous jurisdictions. Blue Cross Blue Shield licensees may offer products on an ASO basis to accounts with headquarters located outside of their licensed areas, provided the other Blue plan with a service area in which the customer is headquartered "cedes" its right to the selling Blue Cross Blue Shield licensee. The duration of the ceding arrangement is determined by the two plans. At December 31, 2004, approximately 38.7% (477,000 members) of our total national account membership, or approximately 9.6% of overall membership, was attributable to ASO business ceded by other plans to us. Most of these ceding arrangements have a three-year term and are subject to renewal.

BlueCard. Under the rules and license standards of the Blue Cross Blue Shield Association, other Blue plans must provide health care to members through the BlueCard program in a manner and scope as consistent as possible to what such member would be entitled to in his or her home region. The Blue Cross Blue Shield Association requires us to pay fees to any host Blue plan that provides these claims and other services to our members who receive care in their service area. Similarly, we are paid fees for providing claims and other services to members of other Blue Cross Blue Shield plans who receive care in our service area.

Claim Reserves

Medical benefits for claims occurring during any accounting period are paid upon receipt of claim and adjudication. We are required to estimate the ultimate amount of claims which have not been reported, or which have been received but not yet adjudicated, during any accounting period. These estimates, referred to as claim reserves, are recorded as liabilities on our balance sheet.

We estimate claim reserves in accordance with Actuarial Standards of Practice promulgated by the Actuarial Standards Board, the committee of the American Academy of Actuaries that establishes the professional guidelines and standards for actuaries to follow. A degree of judgment is involved in estimating reserves. We make assumptions regarding the propriety of using existing claims data as the basis for projecting future payments. Factors we consider include medical cost trends, the mix of products and benefits sold, internal processing changes and the amount of time it took to pay all of the benefits for claims from prior periods. Differences between actual experience and the assumptions made in establishing the claim reserves may lead to actual costs of benefits provided to be greater or less than the estimated costs of benefits provided. The change in the claim reserve estimate during the accounting period is reported as a change in medical expense.

Employees

At January 3, 2005, we employed approximately 5,500 employees in our offices in New York City, Albany, Middletown, Yorktown Heights, Melville, Syracuse and Bohemia, New York, as well as Harrisburg,

Pennsylvania, and several other smaller locations. Approximately 1,500 of these employees are engaged in administration of our contracts with CMS, under which we act as a fiscal intermediary for the Medicare Part A program and a carrier for the Medicare Part B program. Twenty-four employees in our internal sales division are subject to a collective bargaining agreement with the Office and Professional Employees International Union. No other employees are subject to collective bargaining agreements. Overall, we believe that our relations with our employees are good, and we have not experienced any work stoppages.

Government Regulation

The business operations of our subsidiary health insurance companies and health maintenance organizations are subject to comprehensive and detailed state regulation in New York and New Jersey, as well as federal regulation. Supervisory agencies, including state health and insurance departments and, in some instances, the state attorney general, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate many aspects of the products and services we offer;
- assess fines, penalties and/or sanctions;
- monitor our solvency and adequacy of our financial reserves; and
- regulate our investment activities on the basis of quality, diversification and other quantitative criteria, within the parameters of a list of permitted investments set forth in applicable insurance laws and regulations.

Our operations and accounts are subject to examination at regular intervals by these agencies. In addition, the federal and state governments continue to consider and enact many legislative and regulatory proposals that have impacted, or would materially impact, various aspects of the health care system. Many of these changes are described below. While certain of these measures could adversely affect us, at this time we cannot predict the extent of this impact.

The federal government and the governments of the states in which we conduct our health care operations have adopted laws and regulations that govern our business activities in various ways. These laws and regulations may restrict how we conduct our business and may result in additional burdens and costs to us. Areas of governmental regulation include:

- licensure;
- policy forms, including plan design and disclosures;
- premium rates and rating methodologies;
- underwriting rules and procedures;
- benefit mandates;
- eligibility requirements;
- geographic service areas;
- market conduct;
- utilization review;
- payment of claims, including timeliness and accuracy of payment;
- special rules in contracts to administer government programs;
- transactions with affiliated entities;
- limitations on the ability to pay dividends;
- transactions resulting in a change of control;

- member rights and responsibilities;
- sales and marketing activities;
- broker compensation;
- quality assurance procedures;
- privacy of medical and other information and permitted disclosures;
- rates of payment to providers of care;
- surcharges on payments to providers;
- provider contract forms;
- delegation of financial risk and other financial arrangements in rates paid to providers of care;
- agent licensing;
- financial condition (including reserves);
- corporate governance; and
- permissible investments.

These laws and regulations are subject to amendments and changing interpretations in each jurisdiction. Failure to comply with existing or future laws and regulations could materially and adversely affect our operations, financial condition and prospects.

The Company is also subject to federal and state laws, rules and regulations generally applicable to public corporations, including, but not limited to, those governed by the Commission, the Internal Revenue Service and state corporate and taxation departments. The Company is also subject to the listing standards of the New York Stock Exchange, or NYSE. The federal government, certain states and the NYSE and other self-regulatory organizations have recently passed or proposed new laws, rules or regulations generally applicable to corporations, including the Sarbanes-Oxley Act of 2002, that affect or could affect the Company. These changes will increase the company's costs and complexity of doing business and may expose the Company to additional potential liability.

State Regulation

Generally. New York state laws and regulations contain requirements relating specifically to, among other things, Empire's financial condition, financial reserve requirements, premium rates, contract forms, utilization review procedures and rights to internal and external appeals, and the periodic filing of reports with the New York Department of Insurance. Empire is also subject to periodic examination by the New York Department of Insurance. WellChoice Insurance of New Jersey is a credit, life, accident and health insurance company licensed in New Jersey by the New Jersey Department of Banking and Insurance to operate in its 16-county service area, and is subject to similar regulation and oversight under New Jersey insurance law.

Empire HealthChoice HMO has a certificate of authority issued by the Department of Health to operate as an HMO in its 28-county service area in New York State. Applicable state statutes and regulations require Empire HealthChoice HMO to file periodic reports with the Department of Health and the Department of Insurance and contain requirements relating to, among others, operations, premium rates and covered benefits, financial condition and marketing practices. These state agencies, together or individually, also exercise oversight regarding our provider networks, medical care delivery and quality assurance programs and reporting requirements, contract forms, including risk-sharing contracts, claims payment standards, compliance with benefit mandates, utilization review standards, including internal and external appeals, and financial condition. Empire HealthChoice HMO is also subject to periodic financial and market conduct examinations by the New York Department of Insurance and the New York Department of Health. In New Jersey, Empire HealthChoice

HMO (operating as WellChoice HMO of New Jersey) is licensed as an HMO in its 16-county service area, and is subject to similar oversight by the New Jersey Department of Banking and Insurance and Department of Health and Senior Services.

Underwriting and Rating Limitations. Health insurers in New York, and health insurers and HMOs in New Jersey, are required to offer coverage on a community rated, open enrollment basis to all small groups seeking coverage and may not utilize medical underwriting. HMOs in New York are also required to offer coverage on a community rated, open enrollment basis to essentially all groups seeking coverage and may not utilize medical underwriting. None of these may decline to accept individuals within a group based on health-related factors. All HMOs operating in New York are required to make coverage available to individuals on a non-group basis, without underwriting and on a community rated basis, through two standard policies with broad, comprehensive coverage. In addition, all HMOs in New York are required to offer a standard product called Healthy New York to individuals and certain qualifying small groups. These requirements apply exclusively to HMOs, and not to health insurers. Insurers and HMOs in New Jersey may opt to community rate small group business by class, so that rates may vary based on certain demographic factors, such as age and sex as well as location. In New Jersey, we have secured an exemption from offering direct pay coverage by paying an assessment to the State, but we do issue the standardized small group products required under New Jersey law.

New York insurers may experience-rate insurance coverage for large groups (over 50 employees) and may apply medical underwriting rules to large groups, but the rates applicable to each member of the group cannot vary based on the individual's medical condition. In New York, Empire HealthChoice HMO must offer almost all coverage on a community rated basis, although we may distinguish between large groups, small groups and individuals for purposes of establishing rates. Experience rating is permitted for our large group POS product. New Jersey insurers and HMOs may experience-rate insurance and HMO coverage for large groups.

Insurers and HMOs cannot terminate coverage of an employer group based on the medical conditions existing within that group. In fact, they can cancel business for groups or individuals for only a limited number of reasons, such as fraud and default in payment of premium. Insurers and HMOs cannot exclude coverage for a pre-existing condition of a new employee of an existing employer group if that employee had previously satisfied a pre-existing condition waiting period with the prior insurer and if that person maintained continuous coverage. These limitations mirror the federal requirements established by the Health Insurance Portability and Accountability Act of 1996, or HIPAA.

Initial rates and rating formulae for all new products in New York require the prior approval of the New York Department of Insurance. Initial rates for all small group and individual products and large group HMO products in New Jersey require the prior approval of the New Jersey Department of Banking and Insurance. In New Jersey, large group rates and rating methodologies for large group PPO products are not filed with the New Jersey Department of Banking and Insurance. Instead, a differential test is filed on a triennial basis, to show the value of the in-network and out-of-network benefits (including copayments and deductibles), which cannot differ by more than 30% or, under certain circumstances, 40%.

Rate increases on experience-rated products in either state do not require prior approval, but in New York, must be consistent with the formula filed with the New York Department of Insurance. Rate increases on community rated products in New York generally can be implemented on a file and use basis that does not require the prior approval of the New York Department of Insurance but are subject to annual minimum medical loss ratio requirements. With respect to rate changes for community rated products, the New Jersey Department of Banking and Insurance has 60 days from the date of receipt of a rate filing to disapprove the filing. Unless the filing is disapproved, the insurer or HMO may use the form on the effective date specified within the filing.

As part of the plan of conversion, we agreed to several restrictions on premium rate increases relating to three categories of our individual members. A discussion of these restrictions is described under "Item 1 – Business - The Plan of Conversion—The Legislation and the Plan."

New York State Hospital Reimbursement. New York hospital rates are governed by the Health Care Reform Act, which was adopted in 1997. The Health Care Reform Act eliminated New York's former state rate-setting system and allows hospitals and health insurance companies to negotiate reimbursement rates. The Act also provides certain funding streams for public goods, including graduate medical expenses and charity care. Graduate medical education expenses are subsidized through a monthly per covered life assessment on insurers, HMOs and self-funded plans. Compensation for hospital bad debts and charity care and certain other programs are funded by a surcharge on hospital services. We pay the surcharge directly to a State-run pool. The legislation is scheduled to expire on June 30, 2005, but we expect the legislature to extend the legislation with some modifications.

Market Stabilization and Stop Loss Pools. The New York State Community Rating Law (the "Community Rating Law") requires insurers and HMOs writing small employer (groups with less than 50 eligible employees) and direct pay (individual) business to participate in certain market stabilization pools ("Pools"). Under the Community Rating Law there are two major Pools: a pool for individual and small group contracts excluding Medicare Supplemental contracts ("non-Med Supp Pool") and a pool for Medicare Supplemental contracts ("Med Supp Pool"). Both Pools operate on a calendar year basis. These Pools are described in greater detail under "Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations – Liquidity and Capital Resources – Market Stabilization Pools." Due to the complexity of the Pools' mechanisms, implementation of the Pools has been delayed in recent years. The New York State Insurance Department is actively working to finalize implementation procedures and we expect the Pools to be operational sometime in 2005.

Other Legislation. During the past several years, New Jersey and New York have enacted significant legislation relating to managed care plans. These recent acts have contained provisions relating to, among other things, consumer disclosure, utilization review, removal of providers from the network, appeals processes for both providers and members, mandatory benefits and products, state funding pools, and provider contract requirements. New York and New Jersey also passed legislation governing the prompt payment of claims that require, among other things, that health plans pay claims within certain prescribed time periods or pay interest and fines. We have not incurred significant fines for prompt pay violations since those laws became effective.

Foreign Laws and Regulations. We may be subject to the laws of states other than those in which we are licensed with respect to persons we cover who reside in those states. We may also be subject to scrutiny from regulatory agencies in those states. We do not believe the costs related to compliance with such laws, if applicable, will have an adverse impact on our business, financial condition or results of operations.

Insurance and HMO Holding Company Laws

WellChoice is regulated as an insurance holding company system and is subject to the insurance holding company laws and regulations of New York and New Jersey as well as similar provisions included in the New York Department of Health regulations. These laws and regulations generally require that insurers or HMOs within an insurance holding company system register with the insurance or health department of each state where they are licensed to do business and to file with those states reports describing capital structure, ownership, financial condition, certain intercompany transactions and general business operations. In addition, various notice and reporting requirements generally apply to transactions between insurance companies or HMOs and their affiliates within an insurance holding company system, depending on the size and nature of the transactions. These laws and regulations also require prior regulatory approval by domestic regulators or prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies or affiliates.

Additionally, the holding company laws and regulations of New York and New Jersey and the Department of Health regulations in New York restrict the ability of any person to acquire control of an insurance company or HMO without prior regulatory approval. Applicable New York statutes and regulations require the prior

approval of the Commissioner of Health for any acquisition of control of Empire HealthChoice HMO, Empire or WellChoice, and the prior approval of the Superintendent of Insurance for any acquisition of control of Empire or WellChoice. Similarly, New Jersey law requires the prior approval of the Commissioner of Banking and Insurance for any acquisition of control of WellChoice, Empire, Empire HealthChoice HMO or WellChoice Insurance of New Jersey. Under those statutes and regulations, without such approval (or an exemption), no person may acquire any voting security of a domestic insurance company or HMO, or an insurance holding company that controls a domestic insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" a domestic insurance company or HMO. "Control" is generally defined by state insurance laws as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Dividend Restrictions

The amount of dividends paid by insurance companies and HMOs are limited by applicable state law and regulations in both New York and New Jersey. Any proposed dividend to WellChoice from Empire, which, together with other dividends paid within the preceding twelve month period, exceeds the lesser of 10% of its surplus to policyholders or 100% of adjusted net investment income will be subject to approval by the New York Department of Insurance. The New Jersey dividend restriction differs slightly from New York's in that any proposed dividend to Empire from WellChoice Insurance of New Jersey, which, together with other dividends paid within the preceding twelve month period, exceeds the greater of 10% of its surplus to policyholders or net income not including realized capital gains will be subject to approval by the Department of Banking and Insurance. Dividends from both Empire and WellChoice Insurance of New Jersey must be paid from earned surplus. Dividends from Empire HealthChoice HMO to Empire in excess of 10% of the admitted assets of Empire HealthChoice HMO will be subject to review and approval by the New York Department of Insurance, the New York Department of Health and the New Jersey Department of Banking and Insurance.

Capital and Reserve Requirements

Empire is subject to capital and surplus requirements under the New York insurance laws and the capital and surplus licensure requirement established by the Blue Cross Blue Shield Association. Each of these standards is based on the NAIC's RBC Model Act. These capital and surplus requirements are intended to assess the capital adequacy of life, accident and health insurers and HMOs, taking into account the risk characteristics of an insurer's investments and products. The RBC Model Act sets forth the formula for calculating the risk-based capital requirements, which are designed to take into account insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under these laws, an insurance company must submit a report of its risk-based capital level to the insurance commissioner of its state of domicile as of the end of the previous calendar year.

The RBC Model Act requires increasing degrees of regulatory oversight and intervention as an insurance company's risk-based capital declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciliary insurance commissioner of a comprehensive financial plan for increasing its risk-based capital to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control, in a rehabilitation or liquidation proceeding. The RBC Model Act provides for four different levels of regulatory oversight depending on the ratio of the company's total adjusted capital (defined as the total of its statutory capital, surplus, asset valuation reserve and dividend liability) to its risk-based capital. The "company action level" is triggered if a company's total adjusted capital is less than 200%, but greater than or equal to 150%, of its risk-based capital. At the company action level, a company must submit a comprehensive plan to the regulatory authority which discusses proposed corrective actions to improve its capital position. A company whose total adjusted capital is between 250% and 200% of its risk-based capital is subject to a trend test. The trend test calculates the greater of any decrease in the margin (i.e., the amount in dollars by which a company's adjusted capital exceeds its risk-based capital) between the current year and the

prior year and between the current year and the average of the past three years, and assumes that the decrease could occur again in the coming year. If a similar decrease in margin in the coming year would result in a risk-based capital ratio of less than 190%, then company action level regulatory action will occur.

The "regulatory action level" is triggered if a company's total adjusted capital is less than 150% but greater than or equal to 100% of its risk-based capital. At the regulatory action level, the regulatory authority will perform a special examination of the company and issue an order specifying corrective actions that must be followed. The "authorized control level" is triggered if a company's total adjusted capital is less than 100% but greater than or equal to 70% of its risk-based capital, at which level the regulatory authority may take any action it deems necessary, including placing the company under regulatory control. The "mandatory control level" is triggered if a company's total adjusted capital is less than 70% of its risk-based capital, at which level the regulatory authority must place the company under its control. Empire currently exceeds the New York minimum risk-based capital level and meets the Blue Cross Blue Shield Association risk-based capital level licensure requirement.

Capital and surplus requirements for Empire HealthChoice HMO, Inc., our HMO subsidiary which is directly owned by Empire, are regulated under a different method set forth in the New York Department of Health's HMO regulations. The regulations require that Empire HealthChoice HMO currently maintain reserves of five percent of its annual New York-based premium income. Empire HealthChoice HMO, with respect to its operations in New York, meets the financial reserve standards of the New York Department of Health. The Department of Health is expected to publish regulations for adoption during 2005 that will increase the required reserves gradually over the next six years to twelve and one half percent of annual premium income. If that requirement changes it will affect all HMOs and we expect we will meet those revised standards. In November 2002, Empire HealthChoice HMO received a $50.0 million capital contribution from Empire, which was made in connection with the transfer of our New York HMO business from Empire HealthChoice, or HealthChoice, to Empire HealthChoice HMO during 2002 in order to ensure compliance with New York capital and surplus requirements. HealthChoice was our parent company prior to our initial public offering in November 2002. Empire HealthChoice HMO is also licensed in New Jersey and there are minimum net worth standards established under New Jersey laws and regulations. Empire HealthChoice HMO, with respect to its operations in New Jersey, meets the minimum net worth standards established under New Jersey law. Empire HealthChoice HMO is also subject to the Blue Cross Blue Shield Association capital and surplus licensure requirement which is applicable to Empire and satisfies that requirement.

Our New Jersey operations are not subject to the Blue Cross Blue Shield Association capital and surplus licensure requirement. At December 31, 2004 WellChoice Insurance of New Jersey met the minimum capital and surplus requirements of the New Jersey Department of Banking and Insurance.

Regulation of financial reserves for insurers and HMOs is a frequent topic of legislative and regulatory scrutiny and proposals for change. It is possible that the method of measuring the adequacy of our financial reserves could change and that could affect our financial condition. However, any such change is likely to affect all companies in the state.

Guaranty Fund Assessments

New York does not have an insolvency or guaranty association law under which health insurance companies such as Empire or Empire HealthChoice HMO can be assessed for amounts paid by guaranty funds for member losses incurred when an insurance company or HMO becomes insolvent. New York does have a law providing that providers of care may not bring collection or litigation actions against consumers for bills unpaid by an insolvent HMO.

However, under Blue Cross Blue Shield Association guidelines, Empire and Empire HealthChoice HMO are required to establish a mechanism which ensures payment of certain claim liabilities and continuation of

coverage in the event of insolvency. Empire and Empire HealthChoice HMO maintain a deposit agreement with the Blue Cross Blue Shield Association for out-of-area services to provide such assurance. The amount of the deposit is approximately 17% of Empire's and Empire HealthChoice HMO's unpaid claim reserves for out-of-area services. At December 31, 2004, the market value and amortized cost of the investment on deposit was $9.6 million.

WellChoice Insurance of New Jersey participates in the New Jersey Life and Health Insurance Guaranty Association, under which it may be required to pay assessments to the State of New Jersey to provide funds to ensure that the liabilities arising under an impaired insurer's policies or contracts are paid when due. The assessments are due only in the event another carrier is impaired. Since its inception, WellChoice Insurance of New Jersey has not been assessed any payments.

Empire HealthChoice HMO is subject to a New Jersey law that requires New Jersey HMOs to contribute over a three-year period to a fund established to meet unpaid contractual obligations of insolvent New Jersey HMOs. To date, Empire HealthChoice HMO has paid assessments of approximately $190,000 as required under this law.

Federal Regulation

ERISA. The provision of services to certain employee health benefit plans is subject to ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the federal Department of Labor. ERISA regulates certain aspects of the relationships between us and employers who maintain employee benefit plans subject to ERISA. Some of our administrative services and other activities may also be subject to regulation under ERISA. Of particular application are the regulations adopted by the Department of Labor that revise claims procedures for employee benefit plans governed by ERISA (insured and self-funded), effective for claims filed on or after July 1, 2002. Given that the state insurance laws in New York and New Jersey, as well as many other states, already contain stringent claim appeal process requirements, the rules have not significantly impacted our operations. However, we cannot predict the ultimate impact on our business and results of operations in future periods.

HIPAA. HIPAA required the adoption of regulations accomplishing three goals:

- ensuring the privacy of personally identifiable health information;
- ensuring the security of personally identifiable health information; and
- standardizing the way certain health care transactions such as claims are handled when they are conducted electronically, and establishing national identifiers for providers, health plans and employers.

The federal Department of Health and Human Services adopted final rules on these topics. The HIPAA privacy rules require health plans, clearinghouses and providers to:

- comply with a variety of requirements concerning their use and disclosure of individuals' protected health information;
- establish rigorous internal procedures to protect health information;
- enter into business associate contracts with those companies to whom protected health information is disclosed; and
- establish procedures to allow individuals to access and amend records maintained by Empire, receive an accounting of certain disclosures, and to establish grievance processes for individuals to make inquiries or complaints regarding the privacy of their records.

We have been in compliance with these privacy requirements since their April 14, 2003 effective date.

In accordance with the final rules standardizing electronic transactions between health plans, providers and clearinghouses, those parties are required to conform their electronic and data processing systems with HIPAA's electronic transaction requirements. The compliance date for these rules was delayed until October 2003 for those plans, including the Company, that filed an extension request by October 2002. Our electronic and data processing systems were fully capable of conducting all electronic transactions in compliance with the rules by the compliance date. However, to address the fact that a significant number of parties, including health care providers, were not ready to conduct transactions in a HIPAA-compliant format by October 2003, CMS asked commercial health plans like us to adopt a contingency plan to allow our trading partners to continue to use a non-compliant format for a limited period of time to help ensure a smooth transition. We have cooperated with this request. By the end of this transition period, which will be determined by CMS, all electronic transactions will be conducted in compliance with these rules. Some states have adopted more stringent requirements for health care information privacy and security than the standards set by HIPAA. We believe we are in compliance with all state privacy and security laws and regulations to which we are subject.

The final security standards became effective on February 20, 2003. We must comply with the security standards by April 21, 2005. They require covered entities to implement a variety of security measures to protect electronic protected health information and include security standards and implementation specifications grouped under one of three categories: administrative, physical and technical safeguards. While we currently have adequate safeguards in place to protect health information, we have also developed additional processes to enable us to implement security measures to comply with the rules. We expect to be fully compliant by April 21, 2005.

In addition, provisions of the federal Gramm-Leach-Bliley Act generally require insurers to protect the privacy of consumers' and customers' non-public personal information and authorize state regulators to enact and enforce privacy standards that meet at least the federal minimum requirements. Like HIPAA, this law sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. In compliance with the Gramm-Leach-Bliley Act, the New York State Department of Insurance issued privacy and security regulations affording New York consumers and customers privacy protections and notice rights and the New Jersey Department of Banking and Insurance issued rules that provide for the safeguarding of customer information. New Jersey already had laws regulating the collection, use and disclosure of information that met or exceeded the Gramm-Leach-Bliley Act requirements, and therefore the New Jersey Department of Banking and Insurance stated that compliance with state law by insurers transacting business in New Jersey is deemed to be compliance with the privacy and notice requirements of the Gramm-Leach-Bliley Act. The Gramm-Leach-Bliley Act also gives banks and other financial institutions the ability to affiliate with insurance companies, which may lead to new competitors in the insurance and health benefits fields.

Our external costs for HIPAA compliance through 2004 were $6.9 million, inclusive of the $0.6 million spent in 2004. In early 2004, final rules were adopted under HIPAA that mandate the use of national provider identifiers as the standard unique health identifier for health care providers to be used in filing and processing health care claims and other transactions by May 2007. We cannot predict the ultimate impact HIPAA will have on our business and results of operations in future periods.

Medicare

Empire HealthChoice HMO operates a Medicare+Choice plan (to be called Medicare Advantage commencing in 2006) pursuant to a contract with CMS under the federal Department of Health and Human Services, and that contract is subject to applicable federal laws and regulations. Our Medicare+Choice members receive their Medicare benefits from our HMO rather than directly from the federal government under the standard Medicare Part A and Part B programs. CMS has the right to audit health plans operating under Medicare contracts to determine their compliance with CMS's contracts and regulations and the quality of care being rendered to the health plan's Medicare members. The contract to participate in the Medicare+Choice program could, under certain circumstances, be terminated by the federal government or by us.

In December 2003, the President signed into law the Medicare Prescription Improvement and Modernization Act, or MMA, which alters the Medicare+Choice program. Under the MMA, Medicare+Choice plans received increased funding from CMS in 2004 which is also available in 2005, provided these funds are used for limited purposes such as to increase benefits or decrease premiums. In 2004 we obtained such additional funding and anticipate continued receipt of such additional funds throughout 2005.

The MMA also amends the entire Medicare+Choice program and will include HMOs, regional PPOs that cover entire regions, health savings accounts, or HSAs, and other plans. CMS has recently announced that the entire State of New York will be deemed a "region" for the Medicare Advantage PPO program. Payment under this program will be based on the submission of bids by plans that wish to participate in the program.

A major component of the MMA is the creation of a Medicare Part D program providing beneficiaries with coverage for outpatient prescription drugs beginning January 1, 2006. Beginning in 2006, all Medicare beneficiaries will have the option of choosing prescription drug coverage as a stand-alone benefit or by joining a Medicare Advantage HMO, regional PPO, HSA or other permitted health plan. Medicare Advantage HMOs and PPOs will be required to offer an out-patient prescription benefit to Medicare beneficiaries as either a standard benefit or through an approved alternative coverage with actuarially equivalent benefits.

MMA also provides for tax-advantaged Health Savings Accounts (HSAs), effective January 1, 2004, to help eligible individuals with high-deductible health insurance plans pay for qualified medical expenses. HSA contributions are permitted up to the applicable plan deductibles, with a cap of $2,600 for individuals and $5,150 for families. HSAs may be offered by employers of all sizes and both the employer and employee can contribute. Employer contributions will not be counted as income and individual contributions will be tax-deductible. HSA balances may be rolled over and accumulated from year to year. Our consumer directed health product includes an HSA option.

We also serve as a fiscal intermediary for the Medicare Part A program and a carrier for the Medicare Part B program. Fiscal intermediaries and carriers for these programs act as agents under contract to the federal government to process and pay claims for one or more designated regions of the United States under the Medicare Part A program for hospital care and the Medicare Part B program for physician and other care. Our contracts with the federal government are cost-based which means we receive reimbursement for certain costs and expenditures from the federal government, which is subject to adjustment upon audit by CMS. The laws and regulations governing fiscal intermediaries and carriers for the Medicare program are complex and subject to interpretation and can expose an intermediary to penalties for non-compliance. Fiscal intermediaries and carriers may be subject to criminal fines, civil penalties or other sanctions as a result of such audits or reviews. While we believe we are currently in compliance in all material respects with the regulations governing fiscal intermediaries and carriers, there are ongoing reviews by the federal government of our activities under our Medicare fiscal intermediary and carrier contracts. The contracts could, under certain circumstances, be terminated either by the federal government or by us.

The Medicare program is annually the subject of legislation in Congress and we cannot predict what additional rules and requirements may be enacted that will impact our business.

Other Government Programs

New York State mandates and/or sponsors several health benefit products for persons who might otherwise be uninsured or require assistance in paying premiums. These include the Child Health Plus, Healthy New York and other state-mandated direct pay products. All HMOs are mandated by law to participate in the Healthy New York and other state-mandated direct pay products and Empire HealthChoice HMO participates in all of these programs. The Child Health Plus program has extensive rules regarding participation and the contract to participate could, under certain circumstances, be terminated by the State government or by us. In New Jersey,

insurers are required to offer certain standard products in the small group market. We have obtained an exemption from the requirement that we offer direct pay (non-group) coverage in New Jersey by virtue of an assessment paid to the State.

In addition, we participate in the Federal Employee Health Benefits Program (FEP) through a contract with the Blue Cross Blue Shield Association. Currently, other FEP contractors are required to comply with federal Cost Accounting Standards. The Blue Cross Blue Shield Association has a waiver from compliance with these standards which must be renewed annually. Failure to renew this waiver could adversely impact this program, and could result in the Blue Cross Blue Shield Association's withdrawal from the program, although regulations are currently being drafted that could make the waiver permanent.

Legislative and Regulatory Initiatives

There has been a continuing trend of increased health care and health insurance regulation at both the federal and state levels. The federal government and many states, including New York and New Jersey, are considering additional legislation and regulations related to health care plans, including, among other things:

- requiring coverage of experimental procedures and drugs and liberalized definitions of medical necessity;
- limiting utilization review and cost management and cost control initiatives of our managed care subsidiaries;
- requiring, at the New York State level, that mental health benefits be treated the same as medical benefits in addition to the existing federal law that imposes requirements relating to parity of mental health benefits;
- exempting physicians from the antitrust laws that prohibit price fixing, group boycotts and other horizontal restraints on competition;
- regulating premium rates, including prior approval of rate changes by regulatory authorities;
- changing the government programs for the uninsured or those who need assistance in paying premiums, including potential mandates that all HMOs or insurers must participate;
- implementing a state-run single payer system that would partially or largely obviate the current role of private health insurers or HMOs; and
- restricting or eliminating the use of formularies for prescription drugs.

In 2003 and 2004, Congress considered, but did not adopt, legislation authorizing association health plans or AHPs to offer health insurance coverage to small groups without state oversight. Specifically, AHPs would be exempt from state insurance laws and subject to minimal federal rules and oversight. State regulated health plans would remain subject to state rules and oversight, thus requiring them to compete with largely unregulated entities for business. In his State of the Union address in January 2005, the President again proposed adoption of legislation authorizing AHPs.

The New York State Attorney General, the New York Insurance Department, the New York Legislature and others are reviewing practices regarding payment of broker commissions. We expect that revised legislation or regulations will be adopted or issued in 2005, which could affect the manner in which we and others in the industry compensate brokers.

The proposed regulatory and legislative changes described above, if enacted, could increase health care costs and administrative expenses, reduce Medicare reimbursement rates and otherwise adversely affect our business, financial condition and results of operations. We cannot predict whether any of the proposed legislation will be enacted.

The Plan Of Conversion

Background

On September 26, 1996, HealthChoice announced its intention to restructure to a for-profit company, based on significant changes in both the regulatory environment and the marketplace affecting the health insurance industry.

In July 1999, HealthChoice filed a proposed plan of restructuring with the New York Department of Insurance, which was revised in November 1999 following public hearings. On December 29, 1999, the Superintendent of Insurance approved the plan with some modification. This plan was never implemented.

The Legislation and the Plan

In January 2002, the Governor of the State of New York signed into law Chapter One of the New York Laws of 2002, which we refer to as the Conversion Legislation, providing an express statutory basis for HealthChoice's right to convert to a for-profit company. Prior to our initial public offering, HealthChoice was our parent company. The Conversion Legislation, specifically Section 4301(j) and Section 7317 of the New York Insurance Law, clarified the statutory authority for the Superintendent of Insurance's review and approval of a conversion plan. Accordingly, on June 18, 2002, HealthChoice filed an amended plan of conversion seeking the Superintendent's approval to convert under the terms of the Conversion Legislation. HealthChoice also requested and obtained approvals from the Superintendent and, where necessary, from the New York Commissioner of Health, the New Jersey Department of Banking and Insurance, CMS and the Blue Cross Blue Shield Association for certain transactions related to the plan of conversion. On August 6 and 7, 2002, public hearings took place in New York City and Albany, respectively, with respect to the plan of conversion. HealthChoice further amended and refiled the plan of conversion on September 26, 2002 in response to various issues raised at the public hearings. On October 8, 2002, the Superintendent issued an Opinion and Decision approving the plan of conversion and concluding that the conversion is in compliance with the Conversion Legislation and does not violate any applicable laws or regulations. The approval and conclusions were subject to several conditions, including the approval by the Superintendent, the Commissioner and CMS of certain of the agreements that we entered into in connection with the conversion, all of which were satisfied.

The plan of conversion, as required by the Conversion Legislation, provided for:

- safeguards to ensure consumers' continued or increased access to coverage and consumer outreach;
- the method for the transfer of contract forms to ensure that current members were not adversely affected by the conversion and had uninterrupted coverage;
- the conversion of HealthChoice from a not-for-profit corporation into a for-profit corporation; and
- the procedures which we were required to take in completing our conversion, including the series of transactions that resulted in The New York Public Asset Fund, or the Fund, and The New York Charitable Asset Foundation, or the Foundation, initially owning all of our shares. The Fund and the Foundation were established by New York State under the Conversion Legislation to receive the value of HealthChoice as part of HealthChoice's conversion to a for-profit company.

As contemplated by the plan, following HealthChoice's conversion into a for-profit corporation and prior to the effectiveness of our initial public offering, the converted HealthChoice transferred 95% and 5% of its capital stock to the Fund and the Foundation, respectively. The Fund and the Foundation then transferred their shares in the converted HealthChoice to WellChoice Holdings of New York, Inc., or Holdings, a then newly formed wholly owned, for-profit subsidiary and the parent company of our principal insurance operating subsidiaries, in exchange for a corresponding amount of our common stock. Consequently, immediately prior to the completion of the offering, WellChoice was 95% owned by the Fund and 5% owned by the Foundation. As part of these transactions, the converted HealthChoice merged with Empire HealthChoice Assurance, Inc., HealthChoice's

indirect, wholly owned subsidiary and existing for-profit insurer, with HealthChoice surviving as "Empire HealthChoice Assurance, Inc." That entity then transferred its administrative and managerial functions to us. In connection with the transactions described in this paragraph, the Fund obtained an exemption from acquisition of control requirements from the Superintendent and the Commissioner in order to hold 10% or more of the outstanding shares of our common stock.

As a result of these transactions, WellChoice became an insurance holding company with Holdings owning our insurance operating subsidiaries. As required by the Conversion Legislation, immediately following the conversion, 95% of the fair market value of HealthChoice, by virtue of the proceeds from their respective sale of shares and the ownership of their remaining initial shares of WellChoice, was held by the Fund and 5% by the Foundation.

In connection with the conversion, HealthChoice transferred and assigned, and WellChoice received and assumed, certain assets and liabilities, including leases and contracts associated with the provision of administrative and management services to our insurance/HMO subsidiaries.

WellChoice was incorporated in Delaware in August 2002. Prior to the completion of the conversion and our initial public offering, WellChoice did not engage in any operations.

As part of the plan of conversion, we agreed to several restrictions on premium rate increases relating to three categories of our individual members. The first category is a small group of members who currently are covered under a comprehensive individual indemnity policy that is no longer sold by us. This group of members is eligible for Medicare by reason of disability and would not be eligible to purchase comparable coverage if their policies were terminated. Current law applicable to us and the Conversion Legislation prohibits us from discontinuing these policies. There are fewer than 250 individuals covered under these policies and new enrollment is prohibited. We agreed in the plan of conversion that we will not discontinue these policies and that we will not increase rates on these policies by more than 10% (or such lesser amount as may be required if the current statute is amended to provide a lower maximum for "file and use" rates) in any 12-month period without the Superintendent's prior approval, which may only be granted following a public hearing.

The second category relates to members covered by our individual Medicare supplemental policies and the third category relates to our individual direct pay voluntary indemnity policies. Currently, we offer three standard Medicare supplemental packages, A, B and H, and at December 31, 2004, approximately 97,000 individuals were covered under these policies and approximately 16,000 members were covered under our individual direct pay voluntary indemnity policies. We agreed that, with respect to the premium rates applicable to our individual Medicare supplemental policies and our individual direct pay voluntary indemnity policies, we will comply with certain provisions of the New York Insurance Law in effect on December 31, 1999 relating to premium rate increases for persons covered under policies issued by Article 43 (not-for-profit) insurers for a period of five years and three years, respectively, following the effective date of the conversion. Specifically, for rate increases applicable to individual Medicare supplemental policies and individual direct pay voluntary indemnity policies during the five-year and three-year periods, respectively:

- we may utilize the "file and use" rate methodology (filed rates will be deemed approved 30 days after submission) for rate increases of up to 10% annually, or such lower amount as may be required if the current statute is amended to provide a lower maximum for file and use rates (provided that the policies do not have a medical loss ratio less than a minimum of 80%); and
- the Superintendent's prior approval following a public hearing will be required for increases that exceed 10% annually.

In addition, we agreed that with respect to our Medicare supplemental policies, rate increases during the sixth, seventh and eighth years following November 7, 2002, the effective date of the conversion, may be implemented upon filing under the "file and use" methodology, provided we have a medical loss ratio of at least

80% (the ratio otherwise applicable to not-for-profit insurers), in contrast to the 75% minimum that is applicable to Medicare supplemental policies issued by for-profit health insurers. During this period, any application for Medicare Supplemental policy rate increases with a medical loss ratio below 80% will require the prior approval of the Superintendent following a public hearing. At the end of the eighth year following the effective date of the conversion, the premium rates for these policies will be subject to the rules applicable to all other for-profit health insurers.

Recently, the New York State Comptroller raised two issues regarding his responsibilities in connection with the conversion and the Fund. Specifically, in October 2004 the Comptroller issued a legal opinion asserting that, contrary to a legal opinion previously received by the Company in connection with its initial public offering in November 2002, he believes that no contract entered into by the Fund which has a value of greater than $15,000, including underwriting agreements, is valid unless approved by the Comptroller under Section 112 of the New York State Finance Law. In addition, the Comptroller asserts that he believes that he is the "custodian" of the WellChoice stock issued to the Fund under the statute authorizing the conversion of the Company to a for-profit entity, and that, based on this requirement, he was a necessary signatory to the voting trust and divestiture agreement between the Company, the Fund and the Bank of New York. Based on this position the Comptroller believes that certain amendments to that agreement are required.

The Company and the Fund disagree with the Comptroller's assertions regarding these issues and are supporting legislation introduced by the Governor of the State of New York to clarify the role of the New York State Comptroller in connection with the Fund. However, if the Comptroller's position regarding Section 112 is correct, all contracts previously entered into by the Fund could be deemed invalid and unenforceable and the Fund may not be able to enter into additional contracts, unless and until the Comptroller's approval is obtained. This issue could be resolved if the Fund submitted its contracts to the Comptroller and obtained approval.

If this issue is not resolved, the dispute could jeopardize the ability of the Fund to meet the sell down requirements set forth in the voting trust and divestiture agreement in a timely fashion. In this regard, in November 2004, WellChoice made an offer to buy back $200 million of WellChoice common stock from the Fund; this offer was not accepted. The next sell down deadline is November 14, 2005, by which time the Fund must reduce its WellChoice ownership to less than 50%. This would require the Fund to sell approximately 10 million shares of WellChoice common stock. In the event the requirement is not met, the voting trust and divestiture agreement stipulates that the WellChoice shares representing ownership in excess of 50% must be transferred to a sales agent, who will then sell the shares as quickly as reasonably possible. Under the terms of the voting trust and divestiture agreement, failure to meet the November 14, 2005 deadline could also result in penalties under the Company's license agreement with the Blue Cross Blue Shield Association, including potential revocation of the license.

The Company is working with the other parties to amend the voting trust and divestiture agreement to resolve the custodial issue. There is no certainty that all of the various entities (the Fund, the Bank of New York, the Blue Cross Blue Shield Association and the Comptroller) will be able to agree on the terms of any such amendment.

Since the issue came to our attention, the Company has worked with all parties to try to resolve these issues. While we believe the matter will be resolved, as the parties are working toward resolution, the timing of any such resolution is unclear and the Company believes that the dispute has reached the point where disclosure may be important to investors.

Additional Factors That May Affect Future Results of Operations

Risks Relating to Our Business

Our inability to address health care costs and implement increases in premium rates could negatively affect our profitability.

Our profitability depends in large part on our ability to accurately predict and manage future health care costs through underwriting criteria, quality initiatives and medical management, product design and negotiation of favorable provider reimbursement rates. The following includes factors that are beyond our control and may adversely affect our ability to predict and manage health care costs:

- higher than expected utilization of services;
- an increase in the number of high-cost cases;
- changes in the population or demographic characteristics of members served, including aging of the population;
- an unexpected increase in provider reimbursement rates due to unfavorable rate negotiations;
- medical cost inflation;
- changes in healthcare practices;
- cost of prescription drugs and direct to consumer marketing by pharmaceutical companies;
- the introduction of new medical technology and pharmaceuticals; and
- the enactment of legislation that requires us to expand the delivery of required benefits.

In addition to the challenge of managing health care costs, we face pressure to contain prices for our products. Our customer contracts may be subject to renegotiations as customers seek to contain their costs. Alternatively, our customers may move to a competitor to obtain more favorable prices. A limitation on our ability to increase or maintain our prices could result in reduced revenues and earnings, which could have an adverse impact on the trading prices of our common stock and the value of your investment.

A reduction in enrollment in our products could affect our business and profitability.

A reduction in the number of members in our products could reduce our revenues and profitability. Factors that could contribute to a reduction in membership include:

- failure to obtain new customers or retain existing customers;
- premium increases and benefit changes;
- failure to successfully implement our growth strategy;
- failure to provide innovative products that meet the needs of our customers or potential customers;
- the withdrawal of a specific product;
- reductions in workforce by existing customers;
- negative publicity and news coverage; and
- A general economic downturn that results in business failures.

Our profitability may be adversely affected if we are unable to maintain our current provider agreements and to enter into other appropriate agreements.

Our profitability is dependent in part upon our ability to contract on favorable terms with hospitals, physicians and other health benefits providers. Our agreements with these providers generally have fixed terms

that require that we renegotiate them periodically. The failure to maintain or secure new cost-effective health care provider contracts may result in a loss in membership or higher costs of benefits provided. Large groups of physicians, hospitals and other providers have in recent years begun to collectively renegotiate their contracts with health insurance companies like us. In addition, physicians, hospitals and other provider groups continue to consolidate to create hospital networks. This cooperation and consolidation among providers increases their bargaining positions and allows them to negotiate for higher reimbursement rates. Demands for higher reimbursement rates may lead to increased premium rates or the loss of beneficial hospitals and physicians and a disruption of service for our members, which in turn could cause a decrease in existing and new business. If this practice continues, it could have an adverse effect on our business, financial condition and results of operations.

If our insurance and claims reserves are inadequate our incurred claims expense would increase and our future earnings could be adversely affected.

We are required to estimate the total amount of claims for healthcare services for enrolled members that have not been reported, or received but not yet adjudicated, during any accounting period. Our results of operations depend in large part on our ability to accurately estimate the amount of these claims and effectively manage healthcare costs. These estimates, referred to as claim reserves, are recorded as liabilities on our balance sheet. We estimate claim reserves in accordance with Actuarial Standards of Practice promulgated by the Actuarial Standards Board, the committee of the American Academy of Actuaries that establishes professional guidelines and standards for actuaries to follow. Factors we consider in estimating future payments include existing claims data, medical cost trends, the mix of products and benefits sold, internal processing changes and the amount of time it took to pay all of the benefits for claims from prior periods. To the extent the actual amount of claims expense is greater than the estimated amount of claims expense based on our underlying assumptions, our cost of benefits provided would increase and future earnings could be adversely affected.

Loss of our New York State or New York City accounts could result in reduced membership and revenue and the need to reallocate or absorb administrative expenses.

As of December 31, 2004, our New York State account covered approximately 998,000 members, or 20.1% of our total membership and 22.8% of our commercial managed care membership, and our New York City account covered approximately 824,000 members, or 16.6% of our total membership and 18.8% of our commercial managed care membership. We provide hospital-only coverage under both of these accounts. The pricing of our products provided to New York State and New York City has historically been renegotiated annually. With respect to the New York State account, effective January 1, 2003, we agreed to new retention or administrative expense pricing covering a three- year period through December 31, 2005, though both parties retain the right to terminate the contract upon six months' notice. For over three years, the New York City account has been subject to a competitive bid process in which we have participated, relating to a five-year contract. At this time, there is no official timetable for awarding the five-year contract. We have agreed to rates with the New York City account for the period from July 1, 2004 through June 30, 2005. The loss of one or both of the New York State and New York City accounts would materially reduce our membership and revenue and require us to reduce, reallocate or absorb administrative expenses associated with these accounts.

The termination of our license agreements to use the Blue Cross and Blue Shield names and marks would have an adverse effect on our business, financial condition and results of operations.

We are a party to license agreements with the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield plans, which entitle us to the exclusive use of the "Cross and Shield," or Blue Cross and Blue Shield names and marks in ten counties in the New York City metropolitan area and in six counties in upstate New York, the non-exclusive right to use the Blue Cross and Blue Shield names and marks in one upstate New York county, the exclusive use of only the Blue Cross name and mark in seven upstate New York counties and the non-exclusive use of only the Blue Cross name and mark in an additional four upstate New York counties. We use these names and marks to identify our products and services in these licensed counties. The Blue Cross and Blue Shield license agreements also contain other requirements and restrictions regarding

our operations and our use of the Blue Cross and Blue Shield names and marks. These requirements and restrictions are subject to change from time to time. New requirements or restrictions could have a material adverse effect on our business, results of operations and financial condition.

Upon the occurrence of any event causing termination of the license agreements, we would cease to have the right to use the Blue Cross and Blue Shield names and marks or to have access to the Blue Cross Blue Shield Association's networks of providers. Although we cannot predict with certainty what effect the loss of those licenses would have on us, we expect that we would lose a substantial portion of our membership. The loss of these licenses would significantly harm our ability to compete in our markets and may require payment of significant monetary penalties to the Blue Cross Blue Shield Association. Furthermore, the Blue Cross Blue Shield Association would be free to issue to another entity, including one of our competitors, a license to use the Blue Cross Blue Shield names and marks in the counties in New York in which we had previously used the Blue Cross and/or Blue Shield names and marks, which would have a material adverse effect on our business, financial condition and results of operations.

Events which could result in termination of our license agreements include, among others:

- failure to maintain capital at specified levels;
- failure to maintain liquidity of greater than one month of underwritten claims and administrative expenses, as defined by the Blue Cross Blue Shield Association, for two consecutive quarters;
- failure to satisfy state-mandated statutory net worth requirements;
- impending financial insolvency;
- a change of control not otherwise approved by the Blue Cross Blue Shield Association or
- a violation of the Blue Cross Blue Shield Association ownership limitations on our capital stock, including any amendment to the voting trust and divestiture agreement which is not approved by the Association or the failure of the Fund to reduce its stockholdings to the ownership limits within the timeframes set forth in the agreement.

In this regard, the Comptroller recently raised two issues regarding his responsibilities with respect to the Fund that could impact our ability to comply with these requirements. Specifically, in October 2004, the Comptroller issued a legal opinion asserting that, contrary to an opinion from counsel previously received by the Company in connection with its initial public offering in November 2002, he believes that no contract entered into by the Fund with a value of greater than $15,000, including underwriting agreements, is valid unless approved by the Comptroller under Section 112 of the State Finance Law. In addition, the Comptroller asserts that he believes that he is the "custodian" of the stock issued to the Fund under the statute authorizing the conversion, and that, based on this requirement, he was a necessary signatory to the voting trust and divesture agreement between the Company, the Fund and The Bank of New York. Based on this position the Comptroller believes that certain amendments to that agreement are required. We disagree with the Comptroller's position regarding these issues.

If the Comptroller's position regarding Section 112 is correct, the Fund may not be able to enter into additional contracts, unless and until the Comptroller's approval is obtained or pending legislation is enacted that would clarify that the Comptroller's approval is not required. The continuation of this dispute could jeopardize the ability of the Fund to meet the sell down requirements set forth in the voting trust and divestiture agreement in a timely fashion. In addition, if the Comptroller's position regarding the custodian issue is correct, the Company will need to amend the voting trust and divestiture agreement. The various entities (the Fund, The Bank of New York, the Blue Cross Blue Shield Association and the Comptroller) may not be able to agree on the terms of any such amendment. Failure to agree to this amendment could jeopardize our license with the Association.

Any merger or acquisition transaction may require the approval of the Blue Cross Blue Shield Association because of the restrictions contained in the license agreements or any current or future policy of the Blue Cross Blue Shield Association.

In addition, our certificate of incorporation contains restrictions on transfer and ownership limitations that correspond to the Blue Cross Blue Shield Association's rules applicable to our licenses of the Blue Cross and Blue Shield names and marks. Our certificate of incorporation (and the Blue Cross Blue Shield Association's ownership limits) restricts beneficial ownership of our voting capital stock to less than 10% for institutional investors and less than 5% for non-institutional investors, both as defined in our certificate of incorporation, as well as ownership of equity securities representing ownership interests, whether voting or nonvoting, in our company to less than 20%. Although we believe that these limitations are enforceable under Delaware law, we are not aware of any case in which a court has specifically addressed this issue. If one of our stockholders violates the ownership limitations and a court does not enforce the provisions of our certificate of incorporation or the Fund breaches the voting trust and divestiture agreement, we could lose our licenses to use the Blue Cross and Blue Shield names and marks.

Regional concentration of our business may subject us to economic downturns in New York State and, in particular, the New York City metropolitan area.

We operate in 28 counties in New York State and substantially all of our revenue is derived from group accounts that have an office in our service areas in New York State or from individual members who reside in the state. This concentration of business in New York exposes us to potential losses resulting from a downturn in the economy of New York State and, in particular, New York City.

In addition, as a high profile, diverse and highly populated city, New York City could be the target of future terrorist attacks, including bio-terrorism and other public health threats, which could significantly increase the risks of our business, such as the risk of significant increases in costs of benefits provided following such an event. For example, a bio-terrorism attack could cause increased utilization of healthcare services, including physician and hospital services, high-cost prescription drugs and other services.

Significant competition from other health care companies could negatively affect our ability to maintain or increase our profitability.

Our business operates in a highly competitive environment, both in the states of New York and New Jersey as well as nationally. Our largest competitors in the New York City metropolitan area include national and regional health insurers such as UnitedHealth Group, Inc.'s subsidiaries: UnitedHealthCare and Oxford Health Insurance, Inc., as well as Aetna, Inc., Health Insurance Plan of Greater New York and Group Health Incorporated. Our major competitors for national accounts customers include UnitedHealth Group, Cigna Corporation and Aetna as well as other "Blue" plans.

Competition in our industry has intensified in recent years, due to more aggressive marketing and pricing practices by other health care organizations, a customer base which focuses on quality while still being price-sensitive, the introduction of new products for which health insurance companies must compete for members and significant merger and acquisition activity. This environment has produced, and will likely continue to produce, significant pressures on the profitability of health insurance companies. Concentration in our industry also has created an increasingly competitive environment, both for customers and for potential acquisition targets, which may make it difficult for us to grow our business. Some of our competitors are larger than us and have greater financial and other resources than we do. We may have difficulty competing with larger health insurance companies, which can create downward price pressures on provider rates through economies of scale. We may not be able to compete successfully against current and future competitors. In addition, in recent years, the nature and means by which participants in the health care and health insurance industries market products and deliver services have changed rapidly. We believe this trend will continue, requiring us to continue to respond to new and, possibly, unanticipated competitive developments. Competitive pressures faced by us may adversely affect our business, financial condition and results of operations.

Our ability to grow our business through acquisitions may be limited by the terms of our license agreements to use the Blue Cross and Blue Shield names and marks.

In order to distribute our products effectively, we must continue to recruit and retain, and establish relationships with, qualified agents and brokers. Skilled agents and brokers are in high demand and we may be unable to continue to recruit and retain, and establish relationships with, such agents and brokers. If such agents and brokers do not help us to maintain our current customer accounts or establish new accounts, our business and profitability could be adversely affected.

We face heavy competition from other health benefits plans to enter into contracts with hospitals, physicians and other providers for our provider networks. Consolidation in our industry, both on the provider side and on the health insurer side, only exacerbates this competition.

Further, Blue Cross Blue Shield plans share their local provider networks under the BlueCard program allowing enrolled members to obtain service when they travel outside of their home plan's service areas. Our license agreements with the Blue Cross Blue Shield Association require us to pay fees to any host Blue Cross Blue Shield member plan in exchange for providing these claims and services to our members in their service area. BlueCard fees are significant for our business and are not incurred by non-Blue health insurers. As non-Blue health insurers are rapidly consolidating through acquisitions, they are able to expand their provider network to better compete with us on national business without the added burden of having to pay these fees. As a result, our premium rates may not be as competitive as those of non-Blue plans, to the extent their cost savings are not offset by the expense of securing national provider networks for their members.

Medicare premiums may not keep up with the cost of health care services we provide under our Medicare+Choice product and we may not be able to maintain our Medicare+Choice membership at current levels.

We offer a Medicare+Choice product through our New York HMO operations. Under the Medicare+Choice program, Medicare beneficiaries have the option of receiving their care through an HMO instead of the traditional Medicare fee-for-service program. At December 31, 2004, we had approximately 56,000 members enrolled in Medicare+Choice, or 1.3% of our commercial managed care membership, which accounted for 11.1% of our commercial managed care premium revenue for the year ended December 31, 2004.

In connection with this product, we receive a fixed per member per month, or PMPM, capitation payment from the Centers for Medicare and Medicaid Services, or CMS, the federal agency that administers the Medicare program. In some counties in which we offer the Medicare+Choice program, we receive additional premiums from our members. We bear the risk that the actual cost of covered health services may exceed the premium payments we receive from CMS and our members. This can happen if the utilization of health care services increases at a faster rate than we expect or if our hospitals and providers demand larger increases than we anticipated. If the costs of health care exceed the amount we receive from CMS, we may be required to increase supplemental premiums or decrease the level of benefits offered. These changes may make our product less attractive to Medicare beneficiaries and, as a result, our Medicare+Choice membership could decrease.

The bidding process for the new Medicare Advantage PPO program could result in reduced levels of payment from CMS for existing business and we may be unsuccessful in bidding for new Medicare Advantage PPO business.

Under the MMA, starting in 2006, the program will be known as the Medicare Advantage program and will include HMOs, regional PPOs that cover entire regions and local PPOs that cover smaller localities. Payment under this program will be based on competitive bids. The bidding process could result in reduced levels of payment from CMS under the Medicare Advantage program. In addition, we do not operate statewide in New York and CMS has recently announced that the entire State of New York will be deemed a "region" for the

Medicare Advantage PPO program. Accordingly, we will need to enter into a joint venture with one or more health insurers in order to compete for this business in New York. We may not be successful in this bidding process.

As a Medicare fiscal intermediary and carrier, we are subject to complex regulations. If we fail to comply with these regulations, we may be exposed to criminal sanctions and significant civil penalties.

Empire is a fiscal intermediary for the Medicare Part A program and a carrier for the Medicare Part B program, which provide hospital and physician coverage to persons 65 years or older. As a fiscal intermediary and carrier, we serve as an administrative agent for the traditional Medicare fee-for-service program and receive reimbursement for certain costs and expenditures, which are subject to adjustment upon audit by CMS. The laws and regulations governing fiscal intermediaries and carriers for the Medicare program are complex, subject to interpretation and can expose a fiscal intermediary and carrier to penalties for non-compliance. Fiscal intermediaries and carriers may be subject to criminal fines, civil penalties or other sanctions as a result of such audits or reviews. However, there can be no assurance that our compliance program will be adequate or that regulatory changes or other developments which occur in the future will not result in infractions of the CMS requirements.

Changes in the Medicare intermediary and carrier contracting process could result in our ceasing to be a Medicare intermediary and carrier, in which event we would no longer be reimbursed for allocated overhead costs.

We have one year agreements with CMS to act as a Medicare fiscal intermediary for the Medicare Part A program and a carrier for the Medicare Part B program under which we are reimbursed for costs and expenses incurred in fulfilling our contractual obligations. These contracts have been renewed by CMS every October for successive one-year periods since 1988. By October 2005, as provided by the MMA, CMS will divide the country into a set number of geographic processing regions for Medicare contracting purposes.

In October 2005, CMS will begin to phase in over a six-year period a mandatory competitive bidding process that will require bidders to enter into five-year contracts covering a specified processing region. The geographic regions to be specified by CMS will in all likelihood differ from the geographic regions that we currently support. In addition, the bidding process will expand the pool of potential contractors to all qualified parties and will no longer be limited only to insurance carriers.

Depending upon the regional specifications and other contract terms, we may choose not to bid on this contract, or if we do bid, we may not be successful in this bidding process, which would result in the loss of this line of business. If we were to cease to serve as a Medicare contractor, we would no longer be reimbursed by CMS for overhead costs and expenses which are currently allocated to these contracts.

We are dependent on the success of our relationship with IBM for a significant portion of our information system resources.

In June 2002, we entered into an agreement with International Business Machines Corporation, or IBM, pursuant to which we outsourced a portion of our core applications development as well as our data center operations and our help desk to IBM through 2012. We are dependent upon IBM for these support functions. If our relationship with IBM is terminated for any reason, we may not be able to find an alternative partner in a timely manner or on acceptable financial terms. As a result, we may not be able to meet the demands of our customers and, in turn, our business, financial condition and results of operations may be harmed.

We may not be adequately indemnified against all possible losses through the terms and conditions of the agreement. In addition, some of our termination rights are contingent upon payment of a fee, which may be significant.

The success of our business depends on developing and maintaining a modernized computer and technology infrastructure.

Our business and operations may be harmed if we do not maintain our information systems and the integrity of our proprietary information. We are materially dependent on our information systems for all aspects of our business operations. Malfunctions in our information systems, security breaches or the failure to maintain effective and up-to-date information systems could disrupt our business operations, alienate customers, contribute to customer and provider disputes, result in regulatory violations, increase administrative expenses or lead to other adverse consequences. The use of patient data by all of our businesses is regulated at federal, state and local levels. These laws and rules change frequently and developments require adjustments or modifications to our technology infrastructure. These and other material changes affecting our information systems could harm our business, financial condition and results of operations.

In addition, to remain competitive, we must maintain up-to-date e-business capabilities that enable interactions with customers, brokers, agents, employees and other stakeholders through web-enabling technology. The failure to maintain effective and up-to-date e-business systems could cause disruptions in our operations, the loss of existing customers and difficulty attracting new customers, each of which could adversely affect our business and profitability.

A substantial legal liability or a significant regulatory action against us could have an adverse effect on our business, results of operations and financial condition.

We are, and in the future may be, a party to a variety of legal actions that affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims and intellectual property related litigation. In addition, because of the nature of our business, we are subject to a variety of legal and regulatory actions relating to our business operations or to our industry, including the design, management and offering of our products and services.

We currently have insurance coverage for some of these potential liabilities. Other potential liabilities may not be recovered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, certain types of damages, such as punitive damages, may not be covered by insurance and insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future.

In September 1999, a group of plaintiffs' trial lawyers publicly announced that they were targeting the managed care industry by way of class action litigation. Since that time, two actions, one purporting to be a class action on behalf of providers and the other brought by the Medical Society of the State of New York, have been commenced against us in New York State court generally challenging managed care practices, including cost containment mechanisms, disclosure obligations and payment methodologies. In August 2003, a similar nation-wide federal putative class action was brought against Empire, the Blue Cross Blue Shield Association and virtually every Blues plan in the country, on behalf of all medical doctors and doctors of osteopathy. This action, known as the *Thomas* litigation, like the two pending state actions, generally challenges managed care practices, including cost containment mechanisms, disclosure obligations and payment methodologies. In October 2003, a substantially similar federal putative class action was brought against Empire, the Blue Cross Blue Shield Association and virtually every Blues plan in the country, on behalf of ancillary providers, such as podiatrists, psychologists, chiropractors, physical therapists, optometrists, opticians, social workers, nurse practitioners and acupuncturists. Again, like *Thomas*, this action, known as the *Solomon* litigation, raises similar allegations, as well as the added allegation that we subject claims submitted by ancillary providers to stricter scrutiny than claims submitted by medical doctors and doctors of osteopathy. We intend to defend vigorously all of these cases. We will incur defense costs and we cannot predict the outcome of these cases. Certain potential liabilities may not be covered by insurance, and a large judgment against us or a settlement could adversely affect our business, financial condition and results of operations.

A substantial decline in our ceding relationships could have an adverse effect on our business.

The rules and license standards of the Blue Cross Blue Shield Association set forth procedures with respect to the provision of insurance to national accounts with employees located in numerous jurisdictions that are covered by more than one Blue Cross Blue Shield licensee. To provide insurance or administrative services to a national account with its principal place of business outside our New York service area, we are required to obtain permission, referred to as "ceding," from the Blue Cross Blue Shield Association member plan with a license in the service area in which the principal place of business is located. Ceding by member plans is voluntary and there is no guarantee that a member plan will continue to cede business to us. Currently, approximately 477,000 national account members, or 9.6% of our total membership, through 15 national accounts, is ceded from four plans. If several of these plans terminated our ceding agreements it could have an adverse effect on our profitability, financial condition and results of operations.

Risks Relating to Our Relationship with the Fund

As long as the Fund owns a significant portion of the outstanding shares of our common stock, we will need the Fund's approval to engage in certain change of control transactions, recapitalizations, restructurings or other similar corporate actions.

The Fund currently owns approximately 61.9% of the outstanding shares of our common stock and all of the Class B common stock. Under a voting trust and divestiture agreement that we entered into with the Fund in connection with the conversion, the Fund has deposited in a voting trust all of its shares that exceed one share less than 5% of the outstanding common stock. The trustee of the voting trust has agreed to vote the shares of common stock owned by the Fund which are held in the voting trust for nominees for director as approved by a majority of the independent members of our board and the trustee has agreed to vote against any nominee for director for whom no competing candidate has been nominated or selected by a majority of the independent members of our board. Likewise, the Fund's shares must be voted in accordance with the recommendation of a majority of our independent board members, but the Fund will be able to direct the vote of these shares freely on a change of control transaction submitted to stockholders. If the matter concerns an employee compensation plan for which stockholder approval is sought, or a precatory stockholder proposal (that is, an advisory proposal made by a stockholder pursuant to Rule 14a-8 under the Securities Exchange Act of 1934 that merely recommends or requests that we or our board of directors take certain actions), the trustee has agreed to vote the trust shares in the same proportions as the shares voted by other holders of our common stock (other than the trustee of the voting trust, the Fund and our directors, officers, trustees of any of our employee benefit plans and those of our affiliates). In addition, the affirmative vote of the Fund, voting separately as the holder of the Class B common stock, subject to certain exceptions, is required for the following actions that would adversely affect the financial interests, voting rights or transferability of the Fund's shares of common stock: a recapitalization or restructuring of our capital stock; the creation of a new class of capital stock; or the creation of a series of preferred stock and the issuance of additional shares of our capital stock. Consequently, for so long as the Fund owns 5% or more of our stock, the Fund may prevent or delay various significant corporate transactions.

The Fund was established under Chapter One of the New York Laws of 2002, which we refer to as the Conversion Legislation, to hold 95% of the fair market value of HealthChoice and its subsidiaries on November 7, 2002, the effective date of the conversion and also the date of our initial public offering. The Fund is responsible for maximizing the value of the assets in the Fund and making disbursements to provide funding for various health care initiatives of the State of New York, in accordance with the direction of the Director of the Division of the Budget. The Fund has a five-member board, three of whom were appointed by the Governor of the State of New York and the remaining two were appointed by the President of the State Senate and the Speaker of the State Assembly, respectively, all in accordance with the Conversion Legislation.

The Fund's best interests may be different from your best interests and may not conform to our strategy or business goals. You should expect the Fund to vote its shares of our stock on the change of control transactions,

recapitalizations, restructurings and similar corporate actions on which it may vote its shares freely in a manner that is in its best interests. Decisions made by, or on behalf of the Fund may be influenced by political or other considerations, including those resulting from future changes in government.

A majority of our independent directors will be able to control the outcome of most other matters submitted to our stockholders for a vote, as long as the Fund owns a substantial percentage of our stock.

Under the voting trust and divestiture agreement the shares deposited in the voting trust by the Fund are voted, as to matters other than those described in the preceding risk factor, including in respect of the election and removal of our directors, consistent with the recommendations of a majority of the independent members of our board. Accordingly, as long as the Fund owns a significant percentage of our outstanding common stock, our board of directors will be able to control the outcome of most matters brought before our stockholders for a vote. While our board is required to act in a manner consistent with its fiduciary duties under applicable law, it may make recommendations with respect to stockholder voting with which you disagree. In addition, these voting restrictions may operate to make it more difficult to remove members of the board of directors and may have the effect of entrenching management, regardless of their performance.

The Fund's and the Foundation's registration rights may limit our ability to raise additional funds through common stock offerings, which could restrict our growth and inhibit our ability to make acquisitions and adversely affect our ability to compete.

We may seek to take advantage of acquisition or other investment opportunities that may arise and may desire to access the public equity markets to secure additional capital to pursue one or more of these opportunities.

Our failure to raise additional capital when required could:

- restrict our growth, both internally and through acquisitions;
- inhibit our ability to invest in technology and other products and services that we may need; and
- adversely affect our ability to compete in our markets.

Our agreements with the Fund and the Foundation do not prevent us from issuing our common stock as consideration to buy another company or from borrowing money or issuing or assuming debt, preferred stock or convertible securities to buy a business. The registration rights agreement with the Fund and the Foundation could limit our ability to raise funds through common stock offerings at times when we may require funds.

Significant sales of our common stock by the Fund, or the expectation of these sales, could cause our stock price to fall.

Pursuant to the voting trust and divestiture agreement, the Fund, as our principal stockholder, is obligated to reduce its ownership of our common stock to certain levels by specified dates. Specifically, the Fund has agreed to reduce its ownership of our shares to less than 50% by November 14, 2005, to less than 20% by November 14, 2007 and to less than 5% by November 14, 2012, in each case subject to extension, which must be approved by the Blue Cross Blue Shield Association in its sole and absolute discretion, for a reasonable period of time in light of the circumstances then affecting, or expected to affect, the market price of our common stock, and other, automatic extensions as set forth in the voting trust and divestiture agreement we have entered into with the Fund. If the Fund fails to reduce its stockholdings to the ownership limits within these timeframes, subject to any extensions, then all the shares the Fund holds in excess of the applicable ownership limit will be placed with a third party sales agent who will arrange for the sale of such excess shares in as prompt a manner as will be commercially reasonable. Until sold, the trustee will vote these excess shares in accordance with the recommendation of an independent majority of our board of directors on all matters. Significant sales of our

common stock by the Fund, or the expectation of these sales, may cause our stock price to fall. The Fund, as our affiliate, is subject to restrictions on resales of our common stock, which may only be sold in a registered offering or in accordance with an exemption for the registration requirements under the Securities Act of 1933, as amended. The Fund has the right to require us to file additional registration statements covering the sale of stock by the Fund and the Foundation. Pursuant to Rule 144 under the Securities Act, the Fund is able to sell limited quantities of our common stock without a registration statement. Any significant sale of common stock by the Fund, or the expectation of such sales, could cause the market price of our common stock to decline and your investment will be adversely affected.

We may not be able to sue, or otherwise enforce our rights against, the Fund due to the doctrine of sovereign immunity.

By virtue of the Conversion Legislation, the Fund, if sued, may argue that it is a state entity and therefore could invoke the doctrine of sovereign immunity, which prohibits or restricts lawsuits against government agencies, as a defense. An inability to sue the Fund could prevent or hinder us from pursuing rights and remedies for breaches by the Fund under the registration rights agreement or the voting trust and divestiture agreement or for violations of securities laws and regulations.

Pending litigation challenging the Conversion Legislation could adversely affect our conversion, our initial public offering or subsequent offerings and, if successful, would likely adversely affect the trading or the price of our common stock.

On August 20, 2002, Consumers Union of U.S., Inc., the New York Statewide Senior Action Council and several other groups and individuals filed a lawsuit in New York Supreme Court challenging Chapter One of the New York Laws of 2002, which we refer to as the Conversion Legislation, on several constitutional grounds, including that it impairs the plaintiffs' contractual rights, impairs the plaintiffs' property rights without due process of law, and constitutes an unreasonable taking of property. In addition, the lawsuit alleges that Empire HealthChoice, Inc., or HealthChoice, has violated Section 510 of the New York Not-For-Profit Corporation Law and that the directors of HealthChoice breached their fiduciary duties, among other things, in approving the plan of conversion. On September 20, 2002, we responded to this complaint by moving to dismiss the plaintiffs' complaint in its entirety on several grounds. On November 6, 2002, pursuant to a motion filed by plaintiffs, the New York Supreme Court issued a temporary restraining order temporarily enjoining and restraining the transfer of the proceeds of the sale of common stock issued in the name of, or on behalf of, the Fund or the Foundation to the State or any of its agencies or instrumentalities. The court also ordered that such proceeds be deposited in escrow with The Comptroller of the State of New York pending the hearing of the application for a preliminary injunction. The court did not enjoin WellChoice, HealthChoice or the other defendants from completing the conversion or our initial public offering. On March 6, 2003, the court delivered its decision dated February 28, 2003, in which it dismissed all of the plaintiffs' claims in the complaint.

However, the February 28, 2003 decision granted two of the plaintiffs, Consumers Union and one other group, leave to replead the complaint to allege that the Conversion Legislation violates the State Constitution on the ground that it is a local law granting an exclusive privilege, immunity and/or franchise to HealthChoice. On April 1, 2003, the remaining plaintiffs filed an amended complaint, asserting the State constitutional claim as suggested in the court's decision. The amended complaint seeks to invalidate the Conversion Legislation and, for the first time, to rescind our initial public offering. On May 28, 2003, the defendants filed motions to dismiss the amended complaint in its entirety, for failure to state a claim. On October 1, 2003, the court dismissed all claims against the individual members of the board of directors of HealthChoice, but denied defendants' motions to dismiss the amended complaint. In its decision, the court stated that the plaintiffs' decision to limit their request for preliminary relief in their original complaint to restraining the disposition of the selling stockholders' proceeds of the initial public offering, but not to block the offering, may affect such ultimate relief as may be granted in the action, but was not a reason to dismiss the amended complaint.

The parties appealed the February 28, 2003 and the October 1, 2003 decisions and on May 20, 2004, the New York State Appellate Division, First Department, unanimously upheld the lower court's decisions on (a) February 28, 2003 to dismiss all of the plaintiffs' claims in the initial complaint and (b) October 1, 2003 to deny defendants' motion to dismiss the amended complaint. In addressing the plaintiffs' allegation that the Conversion Legislation is prohibited by the State Constitution and therefore invalid, the court rejected the defendants' position that the Conversion Legislation does not fall within the constitutional prohibition. The court stated that the language of the constitutional prohibition, at least facially, provides no support for an exception for the Conversion Legislation. On June 24, 2004, all parties filed motions before the Appellate Division requesting that the cases be certified for immediate review by the New York State Court of Appeals to determine whether the Appellate Division's May 20, 2004 decision was proper. On October 12, 2004, the Appellate Division granted these motions. Per a briefing schedule set by the Court of Appeals, opening briefs and the record on appeal were filed on January 4, 2005, opposition briefs for all parties are due on March 9, 2005 and reply briefs for all parties are due on March 21, 2005. No date has been set for oral argument, but we expect that it will occur during the spring of 2005.

The parties have agreed to stay the lower court proceedings, pending resolution of all appeals of both motions. Pursuant to a stipulation, pending the final disposition of the appeals, the proceeds of any sale of any of our stock issued in the name of, or on behalf of, the Fund or the Foundation, shall be transferred to The Comptroller of the State of New York, to be held in escrow in a separate interest bearing account.

If the plaintiffs are successful in this litigation (or in any new litigation challenging the Conversion Legislation), there could be substantial uncertainty as to the terms and effectiveness of the plan of conversion, including the conversion of HealthChoice into a for-profit corporation, the issuance of the shares of our common stock in the conversion, or the sale of our common stock in our initial public offering, our June 2004 secondary public offering or in any other public offering. Any such development could have an adverse impact on our ability to conduct our business and would likely have an adverse impact on the trading or the prevailing market prices of our common stock.